AN EPIDEMIOLOGICAL STUDY OF MENTAL ILLNESS

(HOSPITAL BAHAGIA, ULU KINTA, PERAK)

by

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An Academic Exercise Submitted In Requirement
For The Fulfilment of Bachelor of Arts (Hons.) Degree
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Kuala Lumpur
1973

ACKNOWLEDGEMENT

I take this opportunity in conveying my thanks to Miss Hing Ai Yun, my supervisor for the many helps and guidance that she has given me in the process of completing this study.

Many thanks also to Doctor Edward Tan, the Director of Hospital Bahagia, Ulu Kinta and Inche Mohd. Taib Ali, Pegawai Pentadbir Kanan, Hospital Bahagia for permitting me to carry out this study in their hospital.

To the Staff of this hospital, I am most grateful for the most warranted cooperation that they have given me.

Finally, many thanks also to those who have helped me in one way or other, especially Che Fadzillah bt. Rashid and her sister, Che Latifah bt. Rashid for taking their time typing out this draft without whose help it can never be completed.

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1973

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CHAPTER ONE

INTRODUCTION

One of the most disturbing social problems in the world today is mental illness. Though it is not so serious in developing and underdeveloped countries but in countries which are well advanced and highly developed this problems has turned out to be very serious indeed. In the United States alone, there are approximately 750,000 persons who are hospitalised in mental institutions (1957) and they occupy some 55% of all hospital beds (1).

In Malaysia, today, this problem is not very serious yet. Though in the past we are not clearly aware about it, today the situation has changed. The Government had spent millions of dollars in trying do deal with it. In Hospital Bahagia alone an amount of $1,025,000 has been allocated for expenditure during the Second Malaysia Plan (Annual Report, Hospital Bahagia 1971).

SCOPE AND PURPOSE OF STUDY

This study is made in Hospital Bahagia, Ulu Kinta which is situated at Tanjong Rambutan, about 10 miles from Ipoh. The Hospital

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(1) Please refer to August B. Hollingshead and F.C. Redlich, 'Social Class and Mental Illness,' J. Wiley & Sons Inc. New York, 1957. In this book the author(s) made a remark on the rate of prevalence of mental illness in the United States.

covers an area of approximately 550 acres. The catchment area that is covered by it is as shown in the table below:

TABLE I: CATCHMENT AREA COVERED BY HOSPITAL BAHAGIA

CATCHMENT AREA	AREA IN SQ. MLS.	POPULATIONS
PERLIS	310	120,991
KEDAH	3648	954,749
PENANG	400	775,440
PERAK	7980	1,569,161
SELANGOR	3160	1,630,707
PAHANG (RAUB DISTRICT)	862	57,548
TOTAL		5,108,596

Source: Population and Housing Census, 1970

From the table it can be seen that the catchment area served by this hospital is approximately 58% of the total population of Malaysia Barat (8,810,348 as per 1970 population census).

Hospital Bahagia was opened in 1911 by the name of "Central Mental Hospital, Tanjong Rambutan." It started with a population of 45 patients, 30 males and 15 females. By 1941 the number of patients had increased to 5000 (Eng - Seong Tan and Nathaniel N. Wagner, 1971) Today, there are about 4000 patients undergoing treatment here daily.

Because the name Central Mental Hospital was popularly associated with 'madness' by the public, in 1971 it was changed to the present name (2). This action was undertaken in the hope of changing the attitude of the public towards mental illness.

(2) See Lapuran Tahunan, Hospital Bahagia Ulu Kinta, 1971.

The main purpose of this study is to find out whether there exists a relationship between mental illness and the following social variables:-

(a) Age group
(b) Race
(c) Religion
(d) Sex
(e) Marital Status
(f) Social Class
(g) Ecological area of residence
(h) Occupation

The Author also studied the administrative system of the hospital. Here he hopes to find out the general attitude towards mental illness from the viewpoint of the staff, as members of society and as staff of the hospital. It is also hope to find out how far the Government has realised on the problem posed by mental illness. This, the author feels, can be judged from the policy implementation by the Government to develop and improve the conditions in the mental hospital.

HYPOTHESES

For the purpose of this study the author has postulated several hypotheses. They are as follows:-

Hypothesis I: The frequency of mental illness is expected to be greater at the 'middle ages' than at 'young and old ages.'

At the 'middle ages' a person will be subjected to the highest amount of stress. This may be caused by the pressure from his job, the increased amount of responsibility, the move to new environment, i.e. from childhood to an adult, and etc.

Hypothesis II: Women are less prone to mental illness than men.

Comparatively a man may have more responsibility than a woman. In this sense a man may be subjected to more mental stress than a woman.

Hypothesis III: The expectancy of mental illness is significantly related to race and religion.

Culturally different race react differently to stress. The amount of stress that a race can withstand also differs. This can be explained if one studies the culture and the religion of these races.

Hypothesis IV: It is also expected that the frequency of mental illness is greater in urban areas than in rural areas.

The amount of competition in urban areas is greater than that in the rural areas. The greater the competition, the greater will be the stress. Life in rural areas is more relaxed than that of urban areas. This is because of the structure and environment of the two areas.

Hypothesis V: The frequency of mental illness suffered by persons who are single is far greater than those persons who are married, divorced or widowed.

This difference in the proportions of single and married may be partially the result of age and class differences. Schizophrenia has the highest number of prevalence. Majority of the schizoprenic came from the lower class and low age group.

Hypothesis VI: The frequency and types of mental illness is related significantly to the individuals position in the class structure of his society.

It has been found that people in the lower class are more prone to mental illness than people who are in the higher class and also that the types of illness that the different class of people suffered are different

These hypotheses are mainly based on several studies made by psychiatrists, psychologists and sociologists in the United States.

and Asia. These studies have shown that there exists a relationship between mental illness and the various social variables like age, sex, race, religion, marital status, and etc. as mentioned earlier.

METHODS OF STUDY

Methods used in a scientific research are varied (3). Pauline Young (1956), in her book on this subject quoted three methods. They are as follows:-

(a) Observation

(b) Questionnaire

(c) Interview

Under observation, it can be in the form of either 'participant' or 'non-participant'. While the interview can be carried out in the form of 'structured' or 'unstructured.' Usually in a research project more than one method is being employed. This is because all these methods have certain short comings.

In this study the author has employed three methods. They are as follows:-

(a) Collection of data from existing records

(b) Observation

(c) Unstructured interview

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(3) For further information on methods in scientific research refer to Pauline Young, 'Scientific Social Survey and Research' Prentice-Hall Inc., 1956 and also J. Goode and Paul K. Hatt, 'Method in Social Research, Prentice - Hall Inc., 1952. Also refer to Claire Selltiz, Marie Jahoda, Morton Deutsch and Stuart W. Cook, 'Research Methods in Social Relations', Holt, Rinehart and Winston, Inc. New York, 1959.

Data collection is made from individual files (4) maintained by the hospital for each patient. Inside these files particulars with regard to the patient are recorded. Below are the particulars that the author extracted from the file for the purpose of this study:(5)

(a) The state where the patient was borned and at the time of admission.

(b) Type of residence - whether rural, urban or metropolis.

(c) Types of ward.

(d) Place and date of birth.

(e) Sex

(f) Race and religion

(g) Age as at time of admission and as at Jan. 1973.

(h) Marital status

(i) Occupation and social status

(j) Number of children in the family

(k) Patients position in the family - whether first, middle or youngest child.

(l) Diagnosis

(m) Period of admission

(n) Number of time admitted

(o) Security cases - cases that are associated with crime

(p) Suicide cases - patient who attempted suicide

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(4) The files are refered to as 'Patient Case Record' as used in the hospital.

(5) See Appendix I which shows the form where the author obtained the particulars.

The second method that he used was 'unstructured interview.' The purpose of this interview is not for the collection of data but rather for the gathering of information which have connection with his study. The author interviewed 35 members of the staff. They are as follows:-

(a) Two consultant psychiatrist - Dr. Edward Tan and Drs. E. B. McGregor.

(b) One medical officer - Dr. T. M. Chin.

(c) One psychiatric Social Worker - Incik Jailani.

(d) Five hospital assistants.

(e) Five staff nurses.

(f) Five junior hospital assistants.

(g) Ten attendants.

(h) One sister.

The aim of the interview is, firstly, to inquire more about the prevalence of mental illness in West Malaysia. Second, to find out the attitudes of the public towards mental illness and people suffering from it. This is acheived by interviewing the staffs, (taken to represent the public), on their attitudes towards mental illness and the patients. Third, to inquire about the administrative system of the hospital and its objectives. The author also tries to find out the set pattern of relationship established between the staff members and the patients.

As with observation, the author tried to observe the pattern of behaviour of the patients.He also observed the behaviour of certain staff towards their jobs and the patients. The most important aspect is to observe the set pattern of relationship established

between the staff and the patients.

The objective of this 'non-participant' observation is mainly to support the information that the author obtained through the interviews with the staff.

PROCESSING OF DATA

After the collection of data is completed, they are then coded. These raw data are then processed and punched into individual data cards. These cards are sorted out by the use of a sorting machine.

PROBLEMS ENCOUNTERED

Like other research works, the author has encountered with several problems or difficulties in the process of finishing this work. They will be discussed here one by one as a guide for others who wish to do a study on this subject. They are as follows:

(i) There are quite a number of files (Patient Case Records) which are very old indeed, some dated as early as 1940. Since they are too old the writing are unreadable due to wear and tear. Because of this the Author is unable to get the particulars that are necessary. There are also files where particulars with regards to the patients are not recorded. As a result many of the information needed will either be recorded 'NIL' or 'DON'T KNOW.'

(ii) The author finds that it is very difficult for him to control the movement of the files. This is because when a medical officer or a psychiatrist come for a 'periodical interview' of the patients their files will be taken out from the cabinet where they are kept. After he is finished with the interview

these files are placed back into the cabinet, mixing them with other files. Sometimes the file are taken out for other purposes by the Hospital Assistants incharge. As a result several files are over-looked for the purpose of the compilation of data.

(iii) In carrying out his observation the author has some difficulty, especially in the female wards. Here he could not really observed the situation to the fullest extent.
The reason is that he is being given a room where he is separated from the patients. The purpose is to protect him from being attacked or disturbed by them (the female patients).
He finds that this is quite true because he has been threatened by a few of them. In one case a middle aged woman came rushing at him and then punched him several times before she could be stopped.

(iv) An interview with the junior female staff is also a problem. They seem to be quite reluctant in answering his questions. They seem to be scared in saying something bad about the hospital or the administration.
Later when the author interviewed one of the Sisters on this matter she explained that the authority is very strict with these junior staffs, especially the Student Nurses and the Assistant Nurses.

(v) Another difficulty that also affects the validity of this study is which concerned the informations given in the files. The author finds that in several files the information given for a particular case in one aspect are being entered several times and each entry differs from the other. For example,

aspects like the types of occupation and marital status. Because of this he has difficulty in extracting the particulars. As a result, in some complicated cases he has to make a 'DON'T KNOW' entry.

The same type of problem arises when making entries on the types of residence, (i.e. whether rural, urban or metropolis). Many entries on this aspect are not being stated specifically in the files. Sometimes only the name of the states are stated, while at other times only the names of the road are stated. Thus in many cases entries on types of residence are left blank.

DEFINATIONS

For the purpose of this study a patient is any persons who are still undergoing treatment during the period Feb. 10th. to March, 27th. 1973. Should a person, at anytime during this period, be discharged he will not be taken to be a patient. Also persons who are admitted from 1st. Jan. 1973 onward are excluded. Persons who are diagnosed as suffering from epilepsy and mental retardation are also excluded, unless they are being diagnosed as suffering from mental illness (see Chapter Two).

A psychiatrist in this study refers only to the consultant specialist attached to Hospital Bahagia (6).

The hospital in this study refers to Hospital Bahagia, Ulu Kinta, Perak.

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(6) A psychiatrist is a specialist in a branch of medicine, psychiatry, which deals with the prevention, diagnosis, and treatment of mental and emotional disorders; he holds the degree of doctor of medicine. In addition to the usual of internship training in general medicine, he has had advance training as a psychiatric resident in a hospital during which he has had intensive experience in the diagnosis and treatment of mental disorders.

GENERAL

The author feels that it is very important for the readers to note on the high percentage of cases of entries with no information. This phenomenon is the result of the difficulties mentioned eslier and it is unavoidable. Because of this, it is questionable whether the findings in this study can be accepted without doubt. Further more, this being his first study attempted, the author wishes to caution the readers when considering the findings.

CHAPTER TWO

MENTAL ILLNESS - WHAT IT IS

When we talk of the number of people who are mentally ill, we become aware that we are speaking of a disease that is not easily defined. Since illness has full meaning only in relation to physical health, we also need to know what mental health is. It is necessary therefore to produce some reasonable working definations that will serve as a basis for our discussion.

For most people the term mental health and mental illness have medical overtones and refer to bodily condition while others add to it a number of connotations: religion, philosophical, social and psychological.

One popular usage of mental health refers to personal status of being and is usually used to mean 'GOOD' mental health. Marie Jahoda (Jahoda, Page 14, 1959) used the term 'normal' (as conforming to accepted standards) to denote good mental health. But what is a good state of being? Does it mean contentment, serenity, satisfaction with one's society and one's role in society? If it does, what becomes of the view that it is good to seek improvement in one's own lot in society? Does the urge to reform, to help, to change evil then become evidence of mental illness?

Stafford Clark defined mental illness as 'the whole range of disturbance of human emotion, judgement, action, and personality whenever this disturbance was sufficiently profound to be con-

sidered abnormal.' (Clark, 1952). But what is to be considered obnormal? How can behaviour be judged to be so unless one knows what normality is and who is to make the judgement? These three questions represent the problem when a defination is to be made on mental illness.

Another group of psychologist considered mental health from the stand point of the relationship between 'environmental stresses' and 'coping resources.' (Becker, 1966, Page 278). In this manner, given a low order of stress, a person with few coping resources can exist quite comfortably. Given highly developed resources an individual can deal with much greater environmental complexity and still maintain the integrity of his personality. In some instances a person's internal adaptive mechanism can be redeveloped so that he campensates, in the face of environmental stress, for a lack of learned ability in his total armament of coping resources. But it must be remembered also that the social environment, apart from the stresses it imposes on the individual, can play a part in determining mental health. When the individual is faced with damage to his personality because his coping rescources are inadequate to meet the stressful situation, the damage can be arrested if the social environment provides sufficient compensatory supports.

Thus, following this group, mental health involves interaction among the individuals strength, the stresses imposed by social environment, and the support provided by the environment.

In other contexts, the meaning of mental illness depends on who is using the term. In many quarters there is disposition to label as mental illness anything that is not liked or is too threatening.

On the community level this view is expressed by unwillingness to deal directly with the genuine issues involved in the most serious social problems of the day.

ATTITUDES TOWARDS MENTAL ILLNESS

Historically, Malaysians, mainly the Malays, Chinese and Indians, believe that mental illness (GILA) is often caused by the patients being possessed by spirits of various discriptions, depending on which group is involved. Among the Malays, this is often the 'Keramat', an animistic spirit belonging to a particular physical location whom the patient had unwillingly or otherwise offended. Among the Chinese, mental illness is often interpreted as a manifestation of the possesion of the patient by the spirit of a dissatisfied ancestor who is demanding obeisance. The Indians believe that the possesing spirit is most likely to be a deity from the Hindu pentheon who is demanding some tribute or who has been offended for some reason or other.

Sometimes mental illness is viewed by these people as the result of charms wrought by some people who is jealous of the patients personal attributes or his success. This is especially true among the Malays community and they term this phenomenon as 'terkena bustan orang.' Even the Chinese and Indians believe in this.

Neurotic complaints are also interpreted by the Chinese as effects of an imbalance between the YIN (the weak, darkness, etc.) and YANG (the strong, brightness, male etc.) principles within the patients bodily system. Thus YIN/YANG balance is a fundemental concept in the traditional Chinese medicine.

As a result of these beliefs, a patient with a mental illness

would usually be brought by his relative to an indegenous practitioner in the first instance. The Malays would go to a bomoh or pawang who will use charms (JAMPI) or some popular herbs in the process to cure the patient depending on what is believed to be the cause or illness, the Chinese would go to the Sinseh or temple mediums and the Indians to the shrine of their fovourite Hindu deity for succor. Sometimes the Chinese or Indians would consult a Malay bomoh if it is believed that the cause is made by an offended keramat. It is only when these indegenious sources have failed that the patient is brouht to the hospital for treatment. This will only take place if the patient is showing violence and anti-social behaviour or else he will be kept in the house as a secret.

Another important reason why treatment in the mental hospital is resisted and agreed to only as a last resort is the social stigma that will be imposed by the society. A person who is found to be mentally ill is socially look down and will bring shame to the family. This attitude is still very strongly upheld by the Malaysians, especially the Malays, Chinese and Indians. This kind of attitude has got be eradicated and there are many ways in which it can be done. One way is through education, especially health education. This will create awareness and understanding among the population towards mental illness.

From the above paragraphs we can see how mental illness is being wrongly interpreted by the Malaysian people. Firstly is the belief that mental illness is caused by offended spirits or charms wrought by people and secondly is the social stigma, whereby the mentally ill is socially degraded. Because of these attitudes people are reluctant to send the patients to the hospital and when

a patient is referred to the hospital he is already in the late stage of development where treatment is very difficult. But today, according to Doctor T. M. Chin, (a medical officer at Hospital Bahagia Ulu Kinta) most of these people have come to realise that it is not the spirits or charms that cause mental illness but rather there is a psychological and scientific explaination to the phenomena. This, according to him, can be clearly seen if one studies the increase in number of patients being referred for treatment at the mental hospital and that most of them come at the early stage of development. But whether this situation is true or not it has yet to be proved.

It is true that there is an increase in the number of patients admitted to the hospital but the increase may be due to the increase in the rate of mental illness itself as a result of rapid growth of industrialisation in the nation. The increase can also be the result of an increase in total population.

NATURE AND VARIETIES OF MENTAL ILLNESS

Mental illness vary in kind and in degree. Some mental illness result from organic lessions (eg. that caused by syphilis of the central nervous system) while others appear to have their root in psychological experiences and to be quite different in quality from somatic diseases.

The symptoms of mental illness are rather 'ideational and behavioural' (Merton, 1966, Page 31). Therefore they reflect cultural emphases as well as disease processes. In this sense many symptoms cannot be adequately interpreted without a knowledge of the norms of the subculture to which the individual belongs. It is also extremely difficult to equate symptoms from one culture to another or

or even from one time to another.

There are two main types of mental illness that are popularly discussed by western psychiatrists. They are, namely, PSYCHOSES and NEUROSES, while others termed it as psychotic and nonpsychotic. Psychosis is a very severe type of mental illness in which the patient is periodically or usually out of contact with reality. While neurosis is a milder emotional disturbances which tend to make adjustment in certain areas of life difficult or almost impossible. Another type is the PSYCHOSOMATIC DISORDERS which entails very real organic symptoms but the malfunction is caused at least in part by psychological reasons.

PSYCHOSIS

Psychosis is the most severe forms of disordered behaviour. Psychotic are disoriented; they halucinate, have difficulty in communication; are unable to accept social controls, are considered irresponsible, and usually require hospitalization for their own protection as well as society's (Weinberg, 1970, Page 389). Psychosis is further divided into the organic and the functional.

ORGANIC PSYCHOSIS

Here the term organic is used because, etiologically, illness of this type is brought about by a physical or organic impairment to brain tissue of the central nervous system. One type of illness that comes under this category is Paresis. It is the result of infection from syphilis which is caused by a micro organism, Treponemum Pallidum. (Kane, 1962, Page 96). This micro organism will destroy the brain tissue. Some of the symptoms of paresis are defects in the reflex actions, particularly in the pupillary reflex to light, dis-

turbance of the speech and difficulty in writing. Another type is called Cerebral Arteriosclerosis, which results from hardening of the arteries in the brain or the growth of tumor. Traumatic psychosis may result from a very sharp blow on the head. A number of boxers experience this type of psychosis. Senile Dementia, which arises from a general aging process, is also considered to be an organic psychosis.

FUNCTIONAL PSYCHOSIS

It results from intense emotional conflicts or from the effects of stress upon the functioning personality. The 'functional' psychoses are so labelled because they are without clearly defined organic cause or identifiable structural change in the brain and are assumed to be psychological in origin, at least to some degree (Merton, 1961, Page 34). According to Weinberg, (1970, Page 389) 'functional psychoses, in medical psychiatry, are considered the malfunctioning of a disturbed organism. The point of view adopted here is that it is the disturbed biosocial personality, not the organism, that creates and is affected by the psychosis.'

There are four major types of functional psychosis, namely; SCHIZOPHRENIA; MANIC DEPRESSIVE PSYCHOSIS (affective disorders); MELANCHOLIA; and PARANOIA.

SCHIZOPHRENIA

Formerly it was known as Dementia Praecox (psychosis of adolescence). This is because of the frequency with which it occurs among young adults (Merton, 1961, Page 34). There are several subtypes of schizophrenia - simple, hebephrenic, catatonic, paranoid and the mixed type. But it must be remembered that the configuration of symptoms

for any single subtype of schizophrenia is not fixed and also that one subtype may have characteristics of another subtype. For example, a catatonic may have delusions of persecution that seem paranoid, or a paranoid may be enveloped in catatonic stupor.

Simple schizophrenia is a retreat from reality or from life. The patient of this type ceases to have an interest in everything; including his works, his studies, his friends his family or even his personal appearence. Talks to motivate him are useless, and in fact they do not really reach him. Still many of these patients are not admitted to mental hospitals because somehow or other they get by.

Hebepheranic schizophrenia is much more severe in its manifestations. The individual shows the symptoms of simple schizophrenia plus considerable words distortion, silly behaviour, and a perculliar laugh.

Catatonic is perhaps the most dramatic of all. In extreme cases an individual may sit on a chair for the whole day with a vanant expression on his face, never uttering a word. The individual may also assume an immobile position and may retain it that way for hours despite a physical discomfort. He also neglects his personal hygine and must be taken care of.

The paranoid type is highly suspecious of people, even his own family. He sometimes believe that people are attempting to kill him, or are constantly following and criticizing him. He may likewise develop delusion of granduer, beleiving that he is someone great - the King or even God.

MANIC-DEPRESSIVE PSYCHOSIS

Sometimes it is termed as affective reactions or affective

disorders. It may constitute a type of cyclical behaviour. At time the patient is highly elated, exitable and talkative. This stage is referred to as the manic phase. On another occasion he may be completely depressed, silent and withdrawn - depressed phase. In other cases some patients only exhibit one of the stages of behaviour. Delusion and hallucinations are common.

Affective disorders tend to be diagnosed during the age period of 30-35 and the rates of females exceed those for male (Dynes, 1964, Page 400). Patients given this diagnosis are more likely to recover completely than are those diagnosed schizoprenic, but recurrences of the illness are quite frequent.

Another type of functional psychosis is Involutional Melancholia. The diagnosis of this type of illness tends to be given by psychiatrists if only the patient is near the phase of physical change of life. The symptoms are very difficult to distinguished from those of the depressed type of manic-depressive psychosis.

Paranoia which have symptoms very much similar to paranoid schizophrenia (hallucination and delusions of graduer and persecution) is rarely been diagnosed nowadays due to the similarity of symptoms.

NEUROSIS

Neurosis is an incapacitating forms of behaviour which arises from anxiety (7). But it does not involve gross falsification of

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(7) According to Weinberg anxiety may be a basic reaction or a situational one. Basic anxiety is formed slowly during infancy and childhood, binds itself into the personality, and affects later behaviour. Situational anxieties arises from intensely situations, such as war, fire, flood, or some other sudden disaster. Situational anxieties are not basically threatening to a person unless past anxieties are aroused. (Weinberg, 1970 Page 386). Also refer to S. Kirson Weinberg, 'Anxiety' and 'Neurosis' in Dictionary of the Social Sciences,' Juluis Gould and William Kolb (Ed.), The Free Press, New York, 1964, p.p. 30-3, 466-467.

social or external reality in the sense of delusions or hallucination, nor is it likely to cause them to engage in violent behaviour with respect either to society or to themselves. They are rather unhappy, anxious, inefficient individuals who do not ordinarily require hospitalization, but who are, nevertheless, in need of psychiatric assistance.

Anxiety refers to a helpless, panic ridden, disorganised condition resulting from one or a series of critically disturbing experiences which greatly threatened a person's self esteem. The anxiety ridden person becomes more diffident, more self pre-occupied, and more uncertain of himself. Since he lacks the confidence to deal with his problems and is apprehensive about a recurrence of his anxiety, he seeks ways to avert the anxiety. These defenses, which comprise the experession of neuroses, result in a retrenched type of personal organisation and circumscribed activity. For example, a student, terrified by the dismal prospect of failing his examinations, awakens in the morning to discover his writing arm is stiff and immobile. Thus he cannot take the examination and is temporarily released from his anxiety. But since the very thought of taking the examination will continue to arouse anxiety, he will strive by every means to avoid taking it; the eventual price is being his persistant avoidance of similar situation.

From the symptom patterns neurosis can be categrised into several types: Anxiety reactions; Phobic reaction; Conversion reaction; Obsessive-compulsive reaction; and Depressive reaction. Coleman (1964), adds in another two types, i.e. Asthenic reaction and Dissocative reactions. But it must be remembered that these categories may overlap or change in the nature of the symptoms.

Anxiety reaction is the most common of the various neurotic reaction patterns. It is characterised by chronic anxiety and apprehensiveness which may be punctuated by recurring episodes of acute anxiety. It differs from other neurotic reactions in that the anxiety is experienced directly (Coleman, 1864, Page 196). Phobic reaction is a persistent fear of some object or situation which present no actual danger or in which the danger is magnified out of all proportion to its actual seriousness. It occurs most frequently among women than men. Conversion reaction (hysteria) is a neurotic defence in which symptons of some physical illness appear without any underlying organic pathology, for example, tics or paralysis. Reaction that do occur are mainly among adolescents and young adults and are much more frequent among women than among men (Purtell et. al., 1951, Siegler et. al., 1960) (8). In obsessive-compulsive reactions, the anxiety is associated with the persistence of unwanted ideas and of repetitive impulse to perform acts which may be considered unreasonable by the patient. In depressive reactions, it is always associated with a feeling of guilt for past failures or deeds.

PSYCHOSOMATIC DISORDERS

Some psychiatrist refers to it as Psychophysiological disorders. This type of illness is caused by emotional stress which take the form of physiological malfunction. In mild cases they may be only headache or skin rash as Ulcerative Colittis, Hyportension, or anorexia nervosa (severe loss of appetite and vomiting) sometimes

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(8) This is quoted by Coleman in his book, 'Abnormal Psychology and Modern Life,' 1964, Page 204.

produce structural changes which may threatened life (Merton, 1961, Page 38). The treatment to this type of disorder takes very much in the form of medical prescriptions with prescribed changes in the life routine. Sometimes psychotherapy is also used.

Psychosomatic disorders are classified according to the organ system affected. Coleman (1964, Page 249) distinguished ten groups. A few examples are as follows: Psychophysiologic muscule-skeletal reaction, including such reactions as backache, muscle cramps and psychogenic rheumatism, Psychophysiologic respiratory reaction, including bronchial spasms, asthma, hay fever, and many others; Psychophysiologic cardiovascular reaction, including abrupt attack of excessive heart action, high blood pressure, vascular spasms and migrane headache.

ACTING - OUT DISORDERS

The term acting-out disorders (Weinberg, 1970, Page 400) describes a loose category of disorders centering around overtly troublesome anti-social activity. This general category comprises of very diverse personility types, which are loosely called psychopathy.

One type of acting-out disorders is psychopath. The patient of this type is neither psychotic nor neurotic, because he is not disorientated and is not afflicted with anxiety and intense guilt. But his slight guilt and his impulse impel him to repeat aggressive and predatory acts despite the injury he inflicts upon others or the difficulty in which he entangles himself. Patients with this type of illness are termed as psychopathics.

MENTAL RETARDATION

In every culture and in all kind of society there have always

been individuals who have manifested subnormal intellectual functioning. Many of these individuals do not have the ability to manage their affairs with ordinary prudence, are not able to profit from ordinary schooling, and are incapable of maintaining themselves in the community. Some cannot grasp even simple concepts. All those conditions are part of what has been termed mental deficiency, mental subnormality, and mental retardation (9).

In the United States there are an estimated number of 5,500,000 children and adults who are mentally retarded (1963) and this constitutes about 3 percent of the total population (Coleman, 1964, Page 518).

Mental retardation is often confused with mental illness. Actually the phenomena representing mental retardation differ significantly from those of mental illness, but like the later term, it encomposses a number of conditions brought about in distinctly different ways. The differences between the two is made, in general, along these lines: the mentally ill person usually has difficulty in psychological areas primarily concerned with emotions and in the ability to cope with social situations and interpersonal relationships; for the mentally retarded the major problem is a defect in intelligence such that the person is not capable of performing mental tasks appropriate to his age and environment. But differentiations is com-

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(9) According to Coleman (1964, Page 519), in the United States feeble-mindedness was used to refer to subaverage intellectual functioning. This in turn give way to the term mental deficiency and more recently to mental retardation. However, some investigators believe that neither term is adequate, suggesting that mental deficiency should be used for cases with demonstrable brain damage or pathology and that mental retardation should be confined to cases suffering from severe sociocultural deficiencies which presumably have retarded the individual's potential intellectual development.

plicated because both conditions may have their origins in biological and physical damage to the brain system, in psychological or social condition which inhibit growth and development, or in crises which are beyond the coping capacity of the individual. Further more retardation and mental illness can occur concurrently in the same individual.

CHAPTER THREE

HOSPITAL BAHAGIA, ULU KINTA

In West Malaysia today there are two major state mental hospitals. One is in the north, situated at Tanjung Rambutan in Perak, known as Hospital Bahagia, Ulu Kinta (formerly known as Rumah Sakit Otak Besar, Tanjung Rambutan). The other is in the south at Tampoi in Johore. This hospital is called Hospital Permai, Tampoi. Comparatively the capacity of Hospital Bahagia is roughly twice that of Hospital Permai. In this chapter the author will only be discussing on Hospital Bahagia, Ulu Kinta since his study is made here.

LOCATION AND STRUCTURE

Hospital Bahagia is situated outside Tanjung Rambutan, about 10 miles North-East of Ipoh. It covers an area of approximately 550 acres, of which 220 acres is covered by building proper and the staff quarters. The remaining 330 acres comprise of farm land and open space.

Structurally this hospital consists of old buildings. The wards resemble very much like prison cells. This, of course, can be explained if one understands the attitude of the public towards those who are considered to be suffering from mental illness. This attitude reflects the purpose of building this hospital, i.e. as a custodial place. But today, according to the Pengarah, Dr. Edward Tan who is also a consultant psychiatrist, steps have been taken by the adminis-

trative body to unlock the doors of the wards, where possible to the public and also to make it looks more like an institution where these unfortunate people are being treated and not imprisoned.

THE WARDS

The wards in this hospital are divided into three classes, i.e. they are divided into first, second and third class wards. Majority of these wards come under third class.

Class one and class two wards are for paying patients. Government servants who are admitted will only have to pay a certain percentage from their gross income. The class three wards are for non-paying patients. From this perspective it is logical then to assume that patients in class one and class two wards receive better treatment as compared to those patients who are in the class three wards, which of course, will boost their chances of recovery.

The author has observed that most of the class three wards are over crowded. As a result several patients in these wards will have to sleep either on the floor or share their beds with 'friends.'

Majority of the wards are dormitory in nature. Only the class one wards possess single bed rooms. Table II below shows the exact division of the wards.

TABLE II: NUMBER OF BEDS AS BY CLASS OF WARD

CLASS OF WARDS	NUMBER OF BEDS			
	SINGLE		DORMITORY	
	MALE	FEMALE	MALE	FEMALE
FIRST CLASS	1	1	8*	14
SECOND CLASS	-	-	60	30
THIRD CLASS	-	-	1900	1100

* This is a double-bed rooms.

SOURCE: Annual Report - Hospital Bahagia, Ulu Kinta 1971

THE STAFF

At the time of this study the number of trained staff available in this hospital is as follows:

(i)	Specialist (Consultant Psychiatrist)	- 3
(ii)	Medical Officers	- 10
(iii)	Sisters	- 7
(iv)	Staff Nurses	- 35
(v)	Hospital Assistants	- 26
(vi)	Assistant Nurses	- 78
(vii)	Junior Hospital Assistants	- 8
(viii)	Psychotherapist	- 3

The number of staff mentioned above are supplied to the author by Dr. Edward Tan (Pengarah). The untrained staff is composed of the Attendants. There are more than 500 of them in this hospital.

The author feels that it is very important to point out here that most of the staff do not receive proper training in psychiatric care. Even the Medical Officers do not have much training in this field although they do have training on psychiatry during their course in medicine at various universities.

THE PATIENTS

As at the end of 1972 the number of patients in Hospital Bahagia stands at 4116. At the time of this study (March 1973) the number of patients is about 4,000. This figure, it seems, varies day by day, but is never below that line. Majority of the patients are in class three wards. The class one and class two patients represent only a small fraction of the total patient population.

There seems to be a system employed in the allocation of patients to the wards. In this respect the wards are distinguished by special names, for example, Acute Psychotic Ward, Rehabilitation Wards, Epileptic Ward, Working Ward, Chronic Ward, and etc. The patients will be allocated to these wards according to the seriousness of their illness and the time factor, that is, depending on the length of time a patient has been hospitalised at one stretch.

What happened here is that after a period of three months of hospitalisation a patient will be reviewed by a Medical Officer through the recommendation of a Hospital Assistant in charge of that particular ward. If he is found to be socially improved (10) he will be recommended for discharge but if no improvement is seen he will either remain in the same ward or be transferred to another ward. But today the transfer of patients from ward to ward is creating a problem to the administration. This is due to the overcrowded nature of the hospitals' wards. As a result transfer of patients is limited to certain important case only. For example, a working patient in the 'Farm' may be transferred to Acute Psychotic Ward should he turned violent and aggressive. This transfer is necessary because this patient may cause injury to other patients since here he can gain access to the farm implements. This is one case where the transfer of patients is unavoidable no matter how overcrowded the receiving ward is.

CATEGORIES OF ADMISSION TO THE HOSPITAL

Admission of patients into Hospital Bahagia, Ulu Kinta are varied.

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(10) The term, socially improved implies that the patient is found to be able to interact with other members of the society, i.e. he is socially adjusted. Here it does not necessarily means the patient has improved totally, i.e. physically or physiologically there may not be any improvement.

There are, at present, three principal methods of admission (Annual Report, Hospital Bahagia 1971). They are as follows:-

(i) Certified Cases

At present this method comprises majority of the admission. Patients are certified, under Form A and Form B of the first Schedule of the Mental Diseases Ordinance 1952, either by a medical officer or a registered medical practitioner.

(ii) Voluntary Cases

(According to section 39 of the Mental Diseases Ordinance, 1952).

Under this method, patients voluntarily agree to be admitted. According to the administrative body, recently there has been an increase in the number of patients seeking voluntary admission into the hospital for care and treatment. Unfortunately there is no figure available for this. To a certain extent this indicates that the public is now aware of the situation.

(iii) Medico - Legal Cases

This method of admission comprises of cases referred to the hospital by order of a Judge or Magistrate under section 342, or the Ruler in Council under section 334 and 348 of the Criminal Procedure Code of Federated Malay States. Patients under this category are kept in separate security section of the hospital. This is because these people have been charged with commiting various crimes, ranging from theft to murder cases.

METHODS OF TREATMENT

In the treatment of mental patients a wide range of medical, psychological and sociological procedures are involved. In severe cases it involved the coordinated teamwork of psychiatrists, clinical psycho-

logists, psychiatric social workers, occupational therapists, psychiatric nurses, and etc. Although all treatments are directed towards improving the adjustment of the mental patients, specific aims of necessity vary somewhat with the patients and with the therapeutic facilities which are available. However, within the limitations of the patients potentialities and life situation and the available facilities, all therapy has the following aims: (i) Physical improvement; (ii) Psychological improvement; (iii) Sociological improvement (Coleman, Page 555, 1964).

(i) Physical Improvement

This includes the correction or allevation of any organic pathology and the improvement of general physical condition.

(ii) Psychological Improvement

This includes the modification of faulty assumptions and reaction patterns, the development of more effective coping techniques, and the openning of pathways towards greater maturity and continuing self-actualization.

(iii) Sociological Improvement

In this aspect it includes the correction of any existing conditions in the life situation of the patients which makes it impossible or difficult for him to achieve an adequate personality adjustment.

Basically, therapeutic work can be divided into two: Medical therapy including shock therapy(insulin shock and electro convulsive), psychosurgery and pharmacotherapy. Psychotherapy can be sub-divided into several sub-types, for example, group therapy, individual therapy, behaviour therapy, occupational therapy, and etc.

TREATMENT IN HOSPITAL BAHAGIA, ULU KINTA

Today, there are three main methods of treatment being employed in this hospital. They are namely: PHARMACOTHERAPY; ELECTRO CONVULSIVE THERAPY; and PSYCHOTHERAPY.

PHARMACOTHERAPY

This method involves the use of drugs. It is popularly employed here. One main reason for this is because it is the most successful method of treatment as compared to the other two methods. The drugs used are psychoactive in nature, mainly in the form of hypnotics, sedatives and stimulants (International Encyclopedia of the Social Sciences, Vol. 10 - Mental Disorder). Though all these drugs give tranquilising effects they do not, like other drugs, lead to addiction.

There are several type of drugs used today. Rauwolfia and phenothiazine derivatives seem to be very popular. They come under the group of major tranquilizers. These drugs are used to control excitement, agitation and thought disturbances. Another group is the antidepressants which are used to elevate mood and increase alertness and interest in the environment. Examples of these drugs are isocarboxazid and imipramine. Anti anxiety drugs or minor tranquilizers are used to decrease tension and apprehension.

One problem in the use of drugs is the amount of dosage to be given to patients. This is because different patients need different amount of dosage. Since one patient need to be given a number of different drugs this can pose as a problem too. The problem lies in the choice of a correct combination of drugs.

Modern pharmacotherapy is very effective in the treatment of patients suffering from acute schizophrenic breakdown. However patients

in depressive condition also respond favourably to this method. In the treatment of 460 neuropsychiatric patients involving a wide range of diagnostic types - including schizophrenia, manic-depressive reaction, involutional depressive reaction and anxiety reaction, Pennington (1962) found that approximately 60% were greatly improved by the combined use of chlorpromazine, meprobanate and an energizer (Coleman, 1964, Page 563). Unfortunately in this study the author is not able to get figures for this purpose with regard to Hospital Bahagia. So he is not able to say exactly how far is the effectiveness of phamacotherapy employed in this hospital.

ELECTRO CONVULSIVE THERAPY

Electro convulsive therapy is not normally used here. It is only employed for the control of acute psychotic conditions and severe retarded depression. The use is comparatively low (Annual Report Hospital Bahagia, 1971).

GENERAL PROCEDURE (Coleman, 1964, Page 556)

The patient is placed in a bed with his limbs either tied or held firmly by the attendants. This is to prevent injury during the convulsion. A gag is placed in between his teeth to prevent him biting his tongue. Arectire or other muscles relaxants are used to 'soften' the seizure and reduce the danger of fractures or dislocation. Electrodes (usually 2) are fastened to his head or temples. Then a current ranging from 70 to 130 volts is applied for a period of 0.1 to 0.5 seconds. Since the current travels faster than the nerve impulse, the patient feels no pain. There is a sudden flexing of the body, usually accompanied by a cry, followed by a tonic phase in which the patient is rigid, and then a clonic phase with generalised convulsions and jerk-

ing contractions of the extremities. The tonic phase lasts for about 10 seconds while the clonic phase for about 30 seconds. Generally the convulsion usually lasts from 30 to 60 seconds.

Following the convulsion, the patient remains unconscious for about 10 to 30 minutes. On regaining consciousness, he usually appears semistuporus, drowsy and confused, complaining of a headache and pain.

The duration of treatment depends primarily on the results obtained and also the type of illness treated. In depressive reactions, maximum benefit may be achieved in 5 to 10 treatments. In patients who improve slowly it may continue up to 20 treatments. If given to schizophrenic patient, 20 or more treatments are usually administered. (International Encyclopedia of the Social Sciences, Vol. 10 - Mental Disorder).

Though fractures, dislocations and some other complications do occasionally occur, fatalities are really very rare. Another danger of using this method is that it might produce permanent impairment of memory due to physical brain changes. This is very true in the case of older patients. In younger patients this danger is very little however.

PSYCHOTHERAPY

The most important ingredient in psychotherapy is talk. This conversation between the patient and the therapist is not an ordinary conversation that we have everyday but it is rather an exchange of meaningful informations. The patient is encouraged to talk to the therapist as if he, the therapist, were various key persons in the patient life experience. He is encouraged to direct his feelings about these people which he has never been able to express satisfactorily,

and which may be the cause of many disabling conflicts. Thus a simple relationship is established. However the relationship is very much one-sided where the patient is doing most of the talking and the therapist listening. Here the patient has an opportunity to ventilate his feelings and eventually to release some of his troublesome conflicts.

How the technique of psychotherapy actually works to affect the patients remains mysterious. However changes take place in the form of reduction of negative effects, correction of thought distortion, liberation from constriction, or a combination of these.

However the issue of effectiveness of psychotherapy remains unsettled, but therapists are convinced that therapy, whatever method it is, has the potential to relieve mental distress. What is really needed is an improvement in the methods to make therapy not only more powerful but more efficient.

In Hospital Bahagia, Ulu Kinta psychotherapy has not been widely employed. This is not because it is not effective but rather because of lack of staff and time. As has been mentioned earlier there are only three psychiatrists here to cope with 4,000 patients. Anyway group therapy has been tried with the class one and class two patients by Dr. T.N. Chin and Drs. E.B. MacGregor as a pilot project. So far it is not known how far this project has been a success.

Two types of therapy that is being practised here are, namely, behaviour therapy and occupational therapy. In behaviour therapy the psychiatrists are aiming at changing certain unwanted or unsocialised habits of the patients, for example, not wanting to wear their clothings or urinating publicly. They termed this project as habit training.

The purpose of this is to be sure that when the patients are being discharged they will not carry along with them these habits. The success of this project will depend very much on the relationship between the staff and the patients. So far it is observed that the aim of this therapeutic work has not been well accomplished. Among other reasons for this is the lack of trained staff available at the hospital and the attitude of the staff itself.

Occupational therapy takes in many forms. Where the male patients are concerned they have the farms of various types, basketry, carpentry and other industry to work with. The female wards are equipped with beauty parlour, tailoring section and gardening. The number of patients involved in this therapeutic work is comparatively small. This is primarily due to lack of staff. At present, there are only three occupational therapists available. The main aim of this type of therapy is to equip the patients with certain responsibility and something to start with after he has been discharged.

STAFF - PATIENT RELATIONSHIP

During the time of this study the author has observed different stages of relationship between the staff and patients. At the highest level, that is, among the specialists and medical officers the relationship with the patients is very loose it seems. Though they are concerned with the treatment of the patients, the only time they come in contact with the patients is when they are performing a periodical interview, (the term used at the hospital), with the patients. The purpose of this interview is to assess the mental state of the patients, whether there is any progress or social improvement. Should there be, then he can be ready for discharge.

What happens during the interview is that when the doctor is given the files of patients to be interviewed he calls them in one by one. For each patient the hospital assistant or staff nurse in charge will feed in informations with regard to the patient's state of mind and general behaviour. The doctor then asks the patient a few questions to test his state of mind. Sometimes the answers given by the patient is being misunderstood by the doctor. This problem arises as a result of communication barrier. For example, take a case where a Chinese doctor interviews a Malay patient. Here the doctor is poor in his Malay and the patient only understands his mother tongue. Sometimes a question asked by the doctor may be wrongly interpreted by the patient not because of his poor state of mind but rather the doctor is unable to express himself properly.

After the doctor has completed his round for the day some notes will be written in the files for further action either by himself or the hospital assistant or staff nurse in charge of the particular ward. The number of times each patient sees the doctor in this manner varies. All will depend on the state of the patient's behaviour and also, vaguely, on the nature of the person who is in charge of any particular ward. The average number of times a patient sees the doctor ranges from three to five times in a year.

Another group which maintains a more pronounced relation with the patients are the hospital assistants and the nurses. Most of these people know the names of each of their patients. Each of them, the hospital assistant and staff nurse, is given a ward to take charge for a certain period. This helps them very much in understanding the patients. It seems that in certain wards a number of patients are

helping the staff in his work and they seem to be friendly. This again has helped the patients to regain their normal behaviour rather quickly.

Unfortunately many of the staff under this group have not been trained in psychiatric care before being sent to the mental hospital. They only receive training in this respect during the training sessions introduced by the administration. In this training sessions they are taught the concept of psychiatric care. They also discuss various problems encountered by them during their day's work. Prior to this, most of them learn through experience and for those who are interested in their work, through some reading. However the author failed to inquire into the number of times this training is being held. Other personnel included in this group are the junior hospital assistants, student nurses and assistant nurses.

At the lowest stage, the group that has a very close contact with the patients are the attendants. This group never at any time received any training in psychiatric care. So it is not surprising that they have their own way of handling the patients. During this study the author observed that one popular way of handling the patients is by imposing <u>fear</u> upon them. What is meant here is that the patients are being threatened, beaten (at times) and shouted at by the attendants. This attitude of handling the patients is being adopted since the beginning of the hospitals. As was told by one attendant, this is the easiest way of handling "orang gila" (mad people). According to them mad people are useless and cannot be reached, so there is no point of talking to them.

But, today, according to the Pengarah steps have been taken, so

as to change this kind of attitude, in the form of group discussion. This type of discussion will be held in every ward and will include the attendants as well. The idea behind this is to create new insight among the staff and also to improve relationship between them.

An interview with a few of the staff reveals that a good percentage do not like to work in this hospital. The reasons given are varied. Many seems to agree with the view concerned with the conditions of the hospital - that the amount of mental stress they have to bear is too great it seems; that it is troublesome and risky to work with the mentally ill and the social stigma that degrades people who are mentally ill is also applicable to those who work in the hospital.

From the reasons given by the staff here, it seems that a similar attitude towards mental illness and its patients as perceived by the public is also being upheld by the staff, (especially those officers of the lower level). The author feels that these situations may pose as a factor that hinders the progress and development of the hospital's aim towards better care and treatment of the patients.

PSYCHIATRIC SOCIAL WORKER

There is at present only one psychiatric social worker attached to this hospital. This officer, however, is not a trained psychiatric social worker. He is on secondment from the Social Welfare Department as a social welfare officer.

A greater part of his work is concerned with cases of discharged patients who are facing difficulty of acceptance by the community. This difficulty can be categorised into two types. The first type is where the patient has no relatives at all. Where this type is concerned

he will contact the Social Welfare Department of various states for help. The second type is where relatives are not prepared to look after the patients. In this case he will try to make home visits, as a last resort, to convince the relatives that it is safe to take the patient home. This is the most important part of his responsibility. Home visit is not only for the purpose of convincing the relatives to take back the patient but it also enables him to study the social and economic conditions of each family.

But since patients come from various states in West Malaysia, and the welfare worker is doing a one-man show, the problem of making home visits arises. One of his major problem is the time factor. Since the catchment area covered by the hospital is too vast he does not have all the time to do this because there are other responsibilities to look into, for example, he has to be in his office too in order to clear other cases.

Another factor that seems to limit the number of home visits made is finance. Home visits can consume large sums of money for travelling and other expenses. It seems that the amount of money allocated for it is too small.

In view of the importance of this project it is only logical that extra staff be posted here and that a bigger sum of money allocated.

RELAPSE

As the author looked through the files of individual patient for the purpose of this study one feature struck his interest, that is, there seems to be a large number of cases of readmission. These cases are caused purely by one particular factor - RELAPSE.

Table III below shows the distribution of the cases of readmission. From this table it can be seen that the percentage of cases of readmission is as high as 71.65%.

TABLE III: DISTRIBUTION OF PATIENTS ACCORDING TO NUMBER OF TIME ADMITTED

NO. OF TIMES ADMITTED	NO. OF PATIENTS
FIRST ADMISSION	876
2 TO 4 TIMES	1858
5 TO 7 TIMES	306
8 AND ABOVE	50
TOTAL	3090

There are several factors that can cause relapses among patients. Below are listed several of these factors:

(i) The lack of knowledge on the part of relatives and society in general with regard to mental illness. This leads to the perception of the mentally ill as useless and troublesome. Thus they are rejected by society and this may result in relapse.

(ii) The patients' attitude towards the illness itself. Many have the idea that when they have been discharged it means they are back to normal. As a result medication is stopped.

(iii) No proper follow-up.

Reasons:

(a) The patients' house may be located very far away from the nearest hospital.

(b) Poor economic condition of the relatives. They may not have extra money to be used for travelling expenses to the far away hospital for the supply

of medication to the patient.

(c) The supply of medicines (drugs) at the out-patient clinic or hospital may be exhausted at the time when the patient comes for his supply.

(iv) Premature discharges. One reason for this may be because of the over-crowded nature of the hospitals' wards and since the number of trained staff is small, they will be exposed to some pressure in making the diagnosis. Another reason may be due to misinterpretation on the nature of the patients by the staff, as a result of communication barrier.

(v) The nature of illness itself - Certain types of mental illness need a longer period of hospitalisation, i.e. they are difficult to be cured, e.g. schizophrenia. Others may need only a short period of hospitalisation, e.g. manic-depressive psychosis, but here recurrence is very frequent.

Before the readers proceed further with the findings in chapters four, five and six in this study the author wishes to remind them that these findings only reflect those cases that are being treated in Hospital Bahagia, Ulu Kinta. Therefore they cannot be taken to represent the total population conclusively. Another aspect that must be remembered is that the percentages in the tables are only calculated according to the total number of patients hospitalised in the hospital. These percentages are not being calculated as a ratio to the total population in the catchment areas covered by the hospital.

CHAPTER FOUR

MENTAL ILLNESS IN RELATION TO RACE, RELIGION, SEX AND AGE

There have been many studies made on the relationship between mental illness and race, religion, sex and age. To quote a number of these studies we have, for example, in Western countries names like Haratio M. Pollock, Oscar J. Kaplan, Robert W. Hyde, and many others. In the East there are people like Dr. Tsung-yi-Lin, Dr. Hsien Rin, Professor M.G. Jayasundera, Dr. Masaaki Kato, Dr. Chen Chin Hsu and H.B.M. Murphy (11)

In this chapter the author will be discussing the findings of his study made on the abovementioned subject. Perhaps before we proceed further it is better that we understand something about the various races found in West Malaysia. To begin with there are three main ethnic groups (races) here namely, MALAY, CHINESE and INDIAN.

The Malays are Muslim by religion. They are mostly found in the rural areas and are mainly devoted to agriculture and fishing. In 1970 more than 67% are involved in agriculture. The Malays comprise

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(11) Drs. Tsung-yi-Lin, Hsien Rin and Chen Chin Hsu made separate studies in Taiwan, Professor M.G. Jayasundera made his study in Ceylon and Dr. Masaaki Kato made a study in Japan. For further informations on these studies made by them please refer to Caudill and Lin (Ed.), "Mental Health Research in Asia and the Pacific," Honolulu, 1966. A summary of Murphy's study in Singapore can be referred to in "Culture and Mental Health" by Opler (Ed.), Macmillan Company, New York, 1959.

of 53.2% (4,685,838) of the total population in West Malaysia (Mid-Year Population Census, 1970). Generally the Malays are polite and gentle in nature. Culturally, a rich emotional relationship between parents and children is highly valued. Child rearing is permissive and affectionate and the young ones are expected to respect the elders. Their women, especially in the rural areas, are generally shy and often uneducated. Polygamy is rarely practised among the Malays and divorce is very common.

The Chinese forms the second largest group, comprising of 35.4% (3,122,350) of the total population (Population Census, 1970). They are largely found in urban areas and are mostly involved in business and commerce. Like the Malays, a rich emotional relationship between parent and child is also highly valued. According to Vaughan (Page 25, 1879) the Chinese parents expect very much from their children, especially from the males. As a rule the women are faithful and the men devoted to their children. The Chinese are made up of several dialectical groups and intermarriage among these groups is seldom practised.

The Indians form the smallest of the three groups. They are mostly southern Dravidians, speaking Tamil, and mainly Hindu by religion (Opler (Ed.), Page 295, 1959). According to Dube, (1955) in an Indian family, consistency of behaviour is less valued than freedom and variety of emotional expression; this is reflected in the family life, where child rearing is affectionate and harsh by turns, where promises are made generously but with no intention of being kept and where aggressiveness, both in the impotent tantrums of the smaller child and bullying of the older, are permitted and encouraged. The

Indians comprise only 10.6% (932,629) of the total population of West Malaysia (Population Census, 1970).

According to the Population Census, 1970 there are 7,651,626 peoples in Malaysia living in areas designated as rural with the remaining 2,787,904 peoples living in areas defined as urban. In another words about 5 out of 7 persons in Malaysia live in rural areas. Urban and rural concentrations among community groups is shown as follows: Among the Malays only 15% (735,339) are found in urban areas with the remaining 85% living in rural areas; Among the Chinese 46.3% (1,645,977) are living in urban areas and 53.7% (1,909,902) are found in rural areas; and among the Indians there are 34.7% (326,808) living in urban areas and the remaining 65.3% (616,136) living in rural areas. This urban and rural concentrations of community groups can also be looked in this way, i.e. of all those living in urban areas 3 out of 5 are Chinese, about 1 out of 4 Malays, and 1 out of 10 Indians.

I. MENTAL ILLNESS AND RACE

Now let us see how mental illness affects these ethnic groups. But before we look into this let's first see the percentage of patients hospitalised according to the types of illness. From Table IV it can be seen that schizophrenia has the highest percentage of hospitalisation, with 62.49%. Manic-depressive psychosis is second with 6.34%. Other types of mental illness diagnosed form only a small percentage of the patients hospitalised. However notice must be given to the very high percentage of schizophrenic patients hospitalised.

The high percentage of patients shown in the table where diagnosis cannot be ascertained is the result of the poor conditions of the existing records maintained. Patients who are coded under 'obser-

vation' are cases where the psychiatrist is not able to make a diagnosis yet due to certain characteristics which seem complicating.

TABLE IV: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO TYPES OF MENTAL ILLNESS

DIAGNOSTIC GROUPS	NO. OF PATIENTS (%)
SCHIZOPHRENIA	62.49
MELANCHOLIA	0.75
DEPRESSION	1.9
MANIC-DEPRESSIVE PSYCHOSIS	6.34
DEMENTIA	2.36
OTHER PSYCHOSES	3.14
NEUROSIS	0.35
OBSERVATION	1.61
NO INFORMATION	21.03

Table V shows the percentage of mental illness prevalent among the various ethnic groups. Here, the race that has the highest percentage of patients hospitalised is the Chinese, with 60.05%. The next race with second highest percentage is the Malay. The recorded percentage is 25.18%. The Indian patients show a percentage of 13.75% and other races comprise only 1.02% of the total patients hospitalised.

Comparing the percentages between the three races, the Chinese patients nearly triple that of the Malays while the Indian's percentage is more than half of the Malay's percentage. However if this ratio is to be compared to that of the normal population then the percentage of the Indian patients hospitalised will be higher than that of the Malays'.

We have seen earlier that schizophrenia is the main illness diagnosed. Referring to Table VI it can be seen that among the Malay pa-

tients hospitalised 60.54% are diagnosed under schizophrenia. While the Chinese percentage for schizophrenia is 64.74% and among the Indians it is 56.94%. Thus it can be concluded that all the three races have a high rate of schizophrenic, though the percentage of Indian patients hospitalised is low as compared to the percentage for all patients hospitalised which is 62.49%.

In the case of manic-depressive psychosis the percentage for Indian patients is high, with 7.53% and that of the Malay patients is low (4.88%) as compared to the total percentage for manic-depressive patients which is 6.34%.

Where dementia is concerned the percentage of Indian patients is again the highest with 4.47%. Here the percentage of Malay patients hospitalised is only 0.9% and that of the Chinese is 2.44%.

To sum up it can be said firstly, that in all races (Malay, Chinese and Indian) schizophrenia is the main illness diagnosed. Secondly, that the percentage of patients hospitalised under manic-depressive psychosis and dementia is comparatively high among the Indian patients. Lastly, that the Malay percentage for manic-depressive psychosis and dementia is comparatively low. However the author is unable to demonstrate the reason for this phenomenon since he is only a student in sociology.

Let us now consider some of the factors which may have influenced the high percentage of hospitalisation of the Chinese patients and the low percentage of Malay patients hospitalised.

In the case of the Chinese one possible reason for this may lie in their belief towards mental illness. Though they believed that mental illness is caused by spirits or charms put upon them, like what the

TABLE V: THE PERCENTAGE OF HOSPITALISATION BY TYPES OF ILLNESS ACCORDING TO RACE

DIAGNOSTIC GROUPS	MALAY	CHINESE	INDIAN	OTHERS
SCHIZOPHRENIA	15.24	38.9	7.83	0.53
MELANCHOLIA	0.23	0.39	0.13	-
DEPRESSION	0.39	1.3	0.16	0.06
MANIC-DEPRESSIVE PSYCHOSIS	1.23	3.92	1.04	0.16
DEMENTIA	0.23	3.92	1.04	0.16
OTHER PSYCHOSES	0.68	1.81	0.55	0.09
NEUROSIS	0.06	0.23	0.06	-
OBSERVATION	0.74	0.71	0.13	0.03
NO INFORMATION	6.38	11.33	3.24	0.09
TOTAL	25.18	60.05	13.75	1.02

TABLE VI: PERCENTAGE OF HOSPITALISATION BY RACE

DIAGNOSTIC GROUPS	MALAY	CHINESE	INDIAN	OTHERS
SCHIZOPHRENIA	60.54	64.74	59.94	50.00
MELANCHOLIA	0.9	0.65	0.94	-
DEPRESSION	1.54	2.16	1.18	6.25
MANIC-DEPRESSIVE PSYCHOSIS	4.88	6.53	7.53	15.63
DEMENTIA	0.9	2.44	4.47	6.25
OTHER PSYCHOSES	2.7	3.03	4.	9.37
NEUROSIS	0.26	0.38	0.47	-
OBSERVATION	2.96	1.19	0.94	3.13
NO INFORMATION	25.32	18.88	23.53	9.37

Malays and Indians believe, but the extent of this belief is not as great as that of the other two races. In this respect many of them who are found to be ill will be sent for treatment by modern, scientific method rather than being treated by indigenous medicine-man, as

compared to the other two races.

Another factor which need consideration here is the degree of tolerance towards persons who are mentally ill. The Chinese, because of their concern for material wealth, will not tolerate any waste of time and money caring for the sick. It must be remembered that caring for the mentally ill people needs a lot of time, money and most of all, patience.

These two possibilities may influence the number of patients sent for treatment to the mental hospital and thus will show a larger number as compared to other races. The next two factors discussed below may influence the number of people having mental breakdowns.

Firstly, since the Chinese are mostly connected with business and highly concerned about material wealth, a failure in achieving these goals may lead to frustration and depression and in this sense it increases the amount of emotional stress that they are facing. As a result a large number of them may be subjected to mental illness.

The second factor is that which concerned the place of residence. Studies elsewhere have shown that people in urban areas are more subjected to mental illness. This is because of the competitive nature of the environment there. Since the Chinese forms the majority of the urban population, this may explain the high percentage of their hospitalisation. But whether type of residence and type of occupation have any relationship with mental illness will be discussed later in this paper.

In the case of the low percentage of hospitalisation among the Malays factors that may have an influence can be summed up as follows: Culturally the Malays are affectionate and tolerable people. In this

aspect even though a member of the family is suffering from mental illness they will do their best to look after him/her at home. The chances here is that they could be treating less severe illness by themselves, thus this may result in the low percentage of hospitalisation.

Another factor that may be considered here is on the belief that mental illness is caused by spirits of various type or through charms (termed as terkena buatan orang). Because of this belief a person found suffering from mental illness will be sent not to the hospital but instead to the bomoh or pawang (indigenous medicine-man) for treatment. In relation to this belief is the attitude among the Malaysians, especially the Malays, that a person who is mentally ill should be kept as a family secret. This is because of some social stigma that it carries along. As a result many of them are not referred to the hospital for treatment.

However the degree of proness to emotional stress among the Malays is probably low. This may have its connection with their culture, religion, and/or type of residence of which will be discussed later.

1.1 RACE AND RELIGION

The percentage of patients hospitalised according to religion has shown no significant differences by race. According to Table VII below Buddhism ranked the highest with 57.28% of the total patients hospitalised. A slight decrease in percentage here, as compared to that of the Chinese patients, is due to several Chinese who are either Islam, Christian or Hindu. The Muslim patients hospitalised shows a percentage of 27.96%, an increase of 2.8% as compared to the Malay's percentage. This is due to other races who are Muslim by religion. In the case of Hinduism, with 11.19%, a decrease of about 2% is seen, as compared to

the percentage of Indian patients hospitalised. As in the case of Buddhism the same explanation applies here.

There are eleven patients whose religion is not known. This is due to either no information is given or the records kept are unreadable.

TABLE VII: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO RELIGION

DIAGNOSTIC GROUPS	ISLAM	BUDDHIST	CHRISTIAN	HINDU	OTHERS	UNKNOWN
SCHIZOPHRENIA	16.41	37.44	2.33	6.05	0.1	0.17
MELANCHOLIA	0.29	0.27	0.03	0.13	0.03	-
DEPRESSION	0.61	1.1	0.03	0.1	0.03	0.03
MANIC-DEPRESSIVE PSYCHOSIS	1.65	3.78	0.03	0.84	0.03	-
DEMENTIA	0.46	1.39	-	0.48	-	0.03
OTHER PSYCHOSES	0.78	1.78	0.03	0.51	-	0.03
NEUROSIS	0.13	0.19	0.03	-	-	-
OBSERVATION	0.87	0.55	0.1	0.1	-	-
NO INFORMATION	6.76	10.78	0.36	2.98	0.06	0.1
TOTAL	27.96	57.28	2.94	11.19	0.25	0.36

From the table given the author feels that it is not possible to give any conclusive statement here whether there exists a relationship between mental illness and religion. The percentage of hospitalisation according to religion seems to coincide with that according to race. In other words in Malaysia race and religion is very much interrelated with each other. So the hypothesis mentioned earlier which states that mental illness is significantly related to religion has to be set aside for later analysis by other researchers.

2. MENTAL ILLNESS AND SEX

Where the relationship between mental illness and sex is concerned many studies that have been made showed that men have a higher rate of mental illness and it has also been found that in certain types of mental illness diagnosed the rate of the female is higher than that of the male(12). Basing on these findings the author, for the purpose of this study, has postulated a hypothesis stating that women are less prone to mental illness than men.

Table VIII shows that there is a significant difference between the percentage of male patients and female patients hospitalised. For all types of mental illness the percentage of male patients hospitalised is 62.85% while the female patients shows a percentage of only 37.15%. The difference, in percentage, between the two is 25.7%. In other words the ratio between male patients to female patients hospitalised is 1 : 0.59.

From the above figures it can be deduced that rate of mental illness among men is high. An important factor that may account for this phenomenon lies in the amount of emotional stress that men are subjected to. Being a man, he is faced with many responsibilities. Generally a man is the bread winner to his family. In this sense he has to work to support the family. His position and occupation may have an influence on the pressure that he has to bear, failure to achieve this may increase that pressure and this may lead to a mental breakdown. Culturally, a

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(12) For a detail analysis on this please refer to Benjamin Malzberg, "Age and Sex in Relation to Mental Disease," in Mental Hygiene Vol. 3; Silvano Arieti (Ed.), "American Handbook of Psychiatry," Vol. 1 (Chapter 7), Basic Books, Inc. 1959, New York; and Benjamin Pasamanick, Dean W. Roberts, Paul W. Lemkau and Dean B. Kreuger, "A Survey of Mental Disease in an Urban Population," in Benjamin Pasamanick (Ed.), Washington D.C. 1959.

woman is considered a weaker party and is not held responsible for the family socio-economic situation, (of course there are exceptional cases to this). As a rule it is not necessary for a woman to work in order to support the family. Another thing is that a woman's status is not determined by her occupation, but rather through her husband's. In this sense, whether she is working or not will not affect her mental health very much.

When the author compares the percentage of male patients to that of the female patients hospitalised by types of mental illness he finds that for depression and melancholia the percentages of female patients hospitalised exceed that of the males. The percentage among female patients for depression and melancholia is 54.25% and 60.87% respectively while that of the males is 45.76% and 39.17% respectively (see Table VIIIA). In the case of melancholia the difference between the two is very distinct, the female patients nearly double that of the males.

TABLE VIII: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO SEX

DIAGNOSTIC GROUPS	MALE	FEMALE
SCHIZOPHRENIA	41.75	20.74
MELANCHOLIA	0.29	0.45
DEPRESSION	0.87	1.04
MANIC-DEPRESSIVE PSYCHOSIS	3.3	3.04
DEMENTIA	1.33	1.04
OTHER PSYCHOSIS	2.04	1.1
NEUROSIS	0.19	0.16
OBSERVATION	0.68	0.94
NO INFORMATION	12.39	8.64
TOTAL	62.84	37.15

Among schizophrenic patients hospitalised the male's percentage is double that of the females. Here the percentage of male patients is 66.8% while that of the female patients hospitalised is only 33.2%.

TABLE VIIIA: PERCENTAGE OF HOSPITALISATION ACCORDING TO SEX BY TYPES OF ILLNESS.

DIAGNOSTIC GROUPS	MALE	FEMALE
SCHIZOPHRENIA	66.8	33.2
MELANCHOLIA	39.13	60.87
DEPRESSION	45.76	54.24
MANIC-DEPRESSIVE PSYCHOSIS	52.04	47.96
DEMENTIA	56.16	43.84
OTHER PSYCHOSIS	64.95	35.05
NEUROSIS	54.55	45.45
OBSERVATION	42.	58.
NO INFORMATION	59.55	40.45

2.1 RACE AND SEX

From Table IX, taking the percentage of male patients alone the distribution is as follows: The Chinese patients have the highest percentage of hospitalisation with 59.17%; second in rank is the Malay patients with 26.57% and thirdly, the Indian patients with 13.07%. Other race only shows a percentage of 1.18%. These percentages here do not show any significant differences. The pattern of hospitalisation, as compared to that for race in general (see Table V), is very similar in nature.

In the case of female patients hospitalised a similar pattern can be seen. Though there are differences between the two, they are too small to be of any significant value.

Comparing the percentages of patients hospitalised according to individual race by sex the results show some significant correlation.

Referring to Table IXA, the percentage of the Malay male patients is 66.32% while that of the female patients is only 33.68%. Here it shows that the number of Malay males hospitalised is double that of the female patients. With the Chinese patients the difference between the male and female, in percentage, is smaller than that between the Malay males and females. In percentage the Chinese male and female patients hospitalised is 61.94% and 38.06% respectively. Among the Indians the percentage between the male and female patients hospitalised is 59.76% and 40.24% respectively. Here the difference in percentage between the two is much smaller than the differences among the Malays and Chinese.

An important aspect that is considered here is the differences in percentage between the male and female patients hospitalised. From the differences it can be deduced that the rate of hospitalisation by sex among the different races varies. Comparatively, on the male side, the percentage for the Malays is the highest. While on the female side, the rate of hospitalisation of Indian females, among other females, is comparatively high.

TABLE IX: PERCENTAGE OF HOSPITALISATION ACCORDING TO SEX BY RACE

RACE	MALE	FEMALE
MALAY	26.57	22.82
CHINESE	59.17	61.50
INDIAN	13.07	14.90
OTHERS	1.18	0.78

TABLE IXA: PERCENTAGE OF HOSPITALISATION ACCORDING TO SEX BY RACE

RACE	MALE	FEMALE	TOTAL
MALAY	66.32	33.68	100
CHINESE	61.94	38.06	100
INDIAN	59.76	40.24	100
OTHERS	71.88	28.12	100

3. MENTAL ILLNESS AND AGE

Studies in Western countries showed that the prevalence of mental illness increases with age (13). However a study made by Murphy in Singapore showed that the rate of mental patients hospitalised decreases with age (14). Basing on these findings the author has postulated a hypothesis which states that the frequency of mental illness is expected to be greater at the middle ages than at young and old ages.

Table X shows the percentage of patients hospitalised according to types of mental illness by age groups. From this table it can be seen that, generally, the percentage of patients hospitalised decreases with age. At age group 21 - 30 the percentage of patients hospitalised seems to be the highest with 34.5%. From this age group the percentage starts to fall, to 27.86% at age group 31 - 40, to 12.36% at age 41 - 50, and to as low as 0.03% at age group 81 - 90.

However a big increase in percentage is seen from age group 20 and below to age group 21 - 30 from 9.61% to 34.5%. This is because

(13) Please refer to Benjamin Malzberg, "Age and Sex in Relation to Mental Disease," in Mental Hygiene, Volume 3.

(14) H.B.M. Murphy, "Culture and Mental Disorder in Singapore," in Marvin K. Opler (Ed.), "Culture and Mental Health," Macmillan Company, New York, 1959.

it rarely affects a person during the younger age.

Between the age 20 years to 30 years a person is undergoing changes in his life pattern. At this age an individual changes from adolescene to adulthood, where he/she has to bear the responsibilities as part of a society and the family. Where a woman is concerned during this period she will have to get married. This new life pattern where she has to bear responsibility as a wife may prove to be stressful for her since in her early days nothing like this ever occurred to her. As a result there may be a frequent mental breakdown at this stage of development.

As time passed many may have adjusted and established their roles in society and their ability to cope up with the stressful situations may have improved as a result of the earlier experiences. Thus from the age 31 years onward the frequency of mental breakdown may decrease. However, this must not be mistaken to represent the demarcation line where frequency of mental illness decreases at this age.

Another possible factor that may influence the percentage of hospitalisation is the percentage in the normal population of a particular age group. A low percentage in the normal population may produce a low percentage of hospitalisation. Here, since the percentage of old people (60 years and above) is low thus it follows that the percentage of hospitalisation will be low.

Referring to Table XA it can be seen that at age group 21 - 30 schizophrenic patients hospitalised is the highest with 38.74%. Patients with manic-depressive psychosis and depression show a high percentage of hospitalisation at age group 31 - 40 with 29.08% and 32.2% respectively. In the case of patients diagnosed under melancholia and

TABLE X: PERCENTAGE OF PATIENTS HOSPITALISED BY AGE

DIAGNOSTIC GROUPS	20 AND BELOW	21-30	31-40	41-50	51-60	61-70	71-80	81-90	90 AND* ABOVE	NOT KNOWN
SCHIZOPHRENIA	6.5	24.21	19.59	6.6	3.01	0.77	0.16	-	0.56	1.38
MELANCHOLIA	-	0.13	0.16	0.23	0.1	0.03	0.03	-	0.03	0.03
DEPRESSION	0.16	0.58	0.16	0.29	0.1	0.07	0.03	-	0.07	0.03
MANIC-DEPRESSIVE PSYCHOSIS	0.26	1.45	1.86	1.3	0.81	0.33	0.07	-	0.13	0.16
DEMENTIA	-	0.25	0.40	0.77	0.55	0.16	0.1	-	-	0.13
OTHER PSYCHOSES	0.23	0.58	0.53	0.45	0.57	0.39	0.25	0.03	-	0.09
NEUROSIS	-	0.23	0.13	-	-	-	-	-	-	-
OBSERVATION	0.32	0.81	0.26	0.1	0.1	0.07	-	-	0.03	0.03
NO INFORMATION	2.14	6.26	4.77	2.62	2.04	0.77	0.23	-	1.32	0.9
TOTAL	9.61	34.50	27.86	12.36	7.28	2.59	0.87	0.03	2.14	2.75

* Where this group is concerned the author feels that it should be excluded. The high percentage here is caused by some technical errors during coding, which is only discovered after the data has been processed.

TABLE XA: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO TYPE OF ILLNESS

DIAGNOSTIC GROUPS	20 AND BELOW	21-30	31-40	41-50	51-60	61-70	71-80	81-90	90 AND * ABOVE	D.K.
SCHIZOPHRENIA	10.41	38.74	30.86	10.56	4.82	1.24	0.25	-	0.88	10
MELANCHOLIA	-	17.39	21.74	30.43	13.04	4.35	4.35	-	4.35	4.35
DEPRESSION	6.78	30.51	32.20	15.25	5.08	3.39	1.69	-	3.39	1.69
MANIC-DEPRESSIVE PSYCHOSIS	4.08	22.96	29.08	20.41	12.76	5.10	1.02	-	2.04	2.55
DEMENTIA	-	10.96	10.44	32.88	23.29	6.85	4.11	-	-	5.48
OTHER PSYCHOSES	7.22	18.56	16.49	14.43	18.56	12.37	8.25	1.03	-	3.09
NEUROSIS	-	63.64	36.36	-	-	-	-	-	-	-
OBSERVATION	20.00	44.	16.	6.	6.	4.	-	-	2.	2.
NO INFORMATION	10.31	29.38	22.15	12.46	9.69	3.69	1.08	-	6.31	4.15

* Where this group is concerned the author feels that it should be excluded. The high percentage here is caused by some technical errors during coding, which is only discovered after the data has been processed.

dementia the highest percentage of hospitalisation is found to be in age group 41 - 50 with 30.43% and 32.88% respectively. While neurotic patients hospitalised has its highest percentage at age group 21 - 30 with a percentage of 63.64%.

An interesting phenomena that can be observed here is that there seems to be a correlation between types of mental illness and age group, i.e. different types of mental illness is found to occur with the highest rate at different age group. However, at the moment, the author is unable to explain why this is so in view of his incapability, (being only a student in sociology).

3.1 AGE AND RACE

Table XI shows the percentage of patients hospitalised according to age group by race. It seems that there is nothing here of any significant value that need to be discussed further. As compared to the percentage of hospitalisation by age group in general a similar pattern exists here, i.e. the percentage of hospitalisation decreases with age, and that the highest percentage is at age group 21 - 30. However an exception has to be made with the Indian's percentage. From the table it shows that the highest percentage of hospitalisation among the Indians is at age group 31 - 40 with a percentage of 31.53%.

As a summary one thing that need to be mentioned here is that the situation where the percentage of hospitalisation decreases with age is applicable to the three community groups - Malays, Chinese and Indians.

3.2 AGE AND SEX

It seems that the percentage of patients hospitalised calculated according to sex also decreases with age. (See Table XII).

However a very interesting correlation is seen when the percentages for male and female patients is compared. From Table XIIA it can be seen that on the male side the percentage of hospitalisation decreases with age, (as compared to the female percentages). The percentage decreases from 67.07% at age group 21 - 30 to 60.63% at age group 31 - 40. It then decreases lower still to 44.44% at age group 71 - 80.

The percentage of female patients, on the other hand, increases with age. It increases from 32.93% at age group 21 - 30 to 39.37% at age group 31 - 40. The percentage then increases further to 55.55% at age group 71 - 80.

TABLE XI: PERCENTAGE OF HOSPITALISED PATIENTS ACCORDING TO RACE BY AGE

AGE GROUP	MALAY	CHINESE	INDIAN	OTHERS
20 AND BELOW	10.93	10.24	4.23	12.5
21 - 30	36.89	35.26	26.82	34.38
31 - 40	25.58	28.09	31.53	21.88
41 - 50	11.05	11.81	16.71	18.75
51 - 60	6.68	6.09	9.18	3.13
61 - 70	2.31	2.53	3.29	3.13
71 - 80	1.16	0.86	0.47	-
81 - 90	-	0.05	-	-
ABOVE 90 *	1.79	1.78	4.	6.25
NOT GIVEN	3.60	2.21	3.76	-

* Please exclude this group - see explaination on Table X.

TABLE XII: PERCENTAGE OF HOSPITALISED PATIENTS ACCORDING TO SEX BY AGE

AGE GROUP	MALE	FEMALE
20 AND BELOW	10.25	8.54
21 - 30	36.82	30.57
31 - 40	26.88	29.59
41 - 50	12.26	12.54
51 - 60	6.64	8.36
61 - 70	1.96	3.66
71 - 80	0.62	1.31
81 - 90	-	0.09
90 ABOVE *	2.47	1.57
NOT GIVEN	2.11	3.83

TABLE XIIA: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO AGE BY SEX

AGE GROUP	MALE	FEMALE
20 AND BELOW	67.01	32.99
21 - 30	67.07	32.93
31 - 40	60.63	39.37
41 - 50	62.30	37.7
51 - 60	57.33	42.66
61 - 70	47.50	52.50
71 - 80	44.44	55.56
81 - 90	-	100.00
90 AND ABOVE *	48.2	51.8

* Please exclude this group - see explaination on Table X.

We have seen earlier how mental illness is related to age, race and sex. Let us now consider some of the factors that may have influenced these relationship. First, let us discuss the decrease in men's percentage according to age.

One possible factor may be because of a decrease of emotional stress. From a young age a man has been subjected to many responsibilities. He has to work to support the family and when he is married he has to support his own family too. At this stage, his job, his family and/or his children may increase the amount of emotional stress. Later in his life when he reaches the age of 50 or 60 years old his children may have grown up and are able to support the family and also at this age he may have retired from his occupation. This situation may not be a threat to his mental health since he has nothing to worry now. Thus it explains the low percentage of hospitalisation among men at old age.

Another factor that may be considered here is the low percentage in normal population of old men. This has its connection with low life expectancy among men because of several reasons. This situation may have a direct influence on the rate of hospitalisation.

Where women are concerned the increase percentage of hospitalisation with age may be due to, firstly, the increase amount of emotional stress. Culturally, a woman is not considered as a bearer of responsibility. As a rule they do not have to work to support the family. So at a young age, a woman may be subjected to less pressure as compared to a man. Later in her life when she is married and has her own children her problem may increase and since she has not experienced much pressure during her early stage of development the possibility of a breakdown among them is high. Then there is the problem of unstable marriages, some of which ended in divorce. A divorce to a woman means problem. Here she may have to work to support herself and her children, if there are any. A divorcee is

always looked down by society. In this sense she may have to lead a lonely life. All this situation increase the amount of stress that she has to bear and usually this appears in the later part of a woman's life.

As compared to men the life expectancy of women is higher. In this sense a woman is expected to survive longer into old age, as a result of their number in the normal population may be bigger than men. In one aspect this increases the frequency of breakdown among woman at old age. In another aspect the influence is more indirect. Here the percentage of hospitalisation is higher since there are more old ladies than old men in the normal population.

SUMMARY

From the datas analysed in this chapter, it is proved that hypotheses I, II and III can be tentatively held to be valid. However the second part of hypothesis III, that religion is expected to be significantly related to mental illness, has to be abandoned since religion seems to be very closely related to race. In the case of sex, it is found that the male patients have a higher rate of hospitalisation as compared to female patients. Where age is concerned the data shows that rate of mental illness decreases with age and that the highest percentage of hospitalisation is concentrated at the 'middle ages.'

However, in certain cases the validity of the findings show some degree of doubt. This is mainly due to the poor state of the existing records maintained by the hospital.

CHAPTER FIVE

MARITAL STATUS AND SIBLING RANK IN RELATION TO MENTAL ILLNESS

1 MENTAL ILLNESS IN RELATION TO MARITAL STATUS

In chapter four the author has shown from the findings of this study the relationship between mental illness and the various social variables like race, religion, sex and age. In this chapter the author will discuss the relationship between mental illness and yet another social variable, that is, marital status.

From Table XIII it can be seen that by marital status the highest percentage of hospitalisation come from patients who are single, with a percentage of 39.68%. The next highest percentage consists of patients who are married with 26.21%. In the case of divorced and widowed patients hospitalised the percentage is very low as compared to that of the patients who are single or married. The percentage for divorced and widowed patients hospitalised is 1.26% and 3.8% respectively.

Since the percentage for cases where the marital status cannot be ascertained is very high the author feels that the readers must not take this finding as conclusive. This high percentage (29.03%) is unavoidable. It is the result of the condition of the files as mentioned earlier in the introduction.

Let us consider some possible reasons which may influence the distribution of mental illness by marital status. One factor that needs consideration is age. In the earlier chapter the author

has shown that the percentage of patients hospitalised between the age group below 20 to 30 years is 44.11% (see Chapter four, table X). Thus this high percentage in this age group may influence the percentage of single patients hospitalised. Another possible factor that may have an influence on rates is the type of illness itself. Schizophrenia is the main type of illness diagnosed in the hospital. The percentage of patients hospitalised with this diagnosis is 62.49% Schizophrenia is said to be mainly prevalent at young age group. Thus this may explain the high percentage of single patients hospitalised.

From table XIIIA it can be seen that patients who are diagnosed under manic depressive psychosis, demantia and other psychosis the percentage is high with patients under the category of 'married' with 34.18%, 35.05% and 31.51% respectively. But unfortunately the percentage of cases where the marital status of patients cannot be ascertained is high too. So the author feels that it is not possible for him to make any conclusive statement here.

TABLE XIII: THE PERCENTAGE OF PATIENTS HOSPITALISED BY TYPES OF ILLNESS ACCORDING TO MARITAL STATUS

DIAGNOSTIC GROUP	SINGLE	MARRIED	DIVORCED	WIDOWED	D.K.
SCHIZOPHRENIA	27.83	15.76	0.74	1.65	16.51
MELANCHOLIA	0.23	0.19	-	0.03	0.29
DEPRESSION	0.52	0.49	0.03	0.13	0.74
MANIC DEPRESSIVE PSYCHOSIS	2.01	2.16	0.06	0.06	1.49
DEMENTIA	0.26	0.74	-	0.26	1.10
OTHER PSYCHOSIS	0.78	1.10	-	0.19	1.07
NEUROSIS	0.19	-	-	0.03	0.13
OBSERVATION	0.68	0.36	0.06	0.06	0.45
NO INFORMATION	7.18	5.40	0.36	0.84	7.25
TOTAL	39.68	26.21	1.26	3.82	29.03

TABLE XIIIA: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO MARITAL STATUS

DIAGNOSTIC GROUP	SINGLE	MARRIED	DIVORCED	WINDOWED	D.K.	TOTAL IN %
SCHIZOPHRENIA	44.54	25.22	1.19	2.64	26.41	100
MELANCHOLIA	30.43	26.09	-	4.35	39.13	100
DEPRESSION	27.12	25.42	1.69	6.78	38.98	100
MANIC DEPRESSIVE PSYCHOSIS	31.63	34.18	1.02	9.69	23.47	100
DEMENTIA	24.74	35.05	-	6.19	34.02	100
OTHER PSYCHOSIS	10.96	31.5	-	10.09	46.58	100
NEUROSIS	54.55	-	-	9.09	36.26	100
OBSERVATION	42.	22.	4.	4.	28.	100
NO INFORMATION	34.15	25.69	1.69	4.	34.46	100

1.1 MARITAL STATUS AND SEX

There seems to be a very interesting correlations between mental illness and marital status when sex variable is included. From table XIV, taking by all types of mental illness the single males shows a very high percentage of hospitalisation as compared to the single female patients hospitalised. Comparatively the number of single male patient hospitalised is more than four times that of the single female patient. The percentage of single male and single female patients is 80.83% and 19.17% respectively.

Where married, divorced and widowed patients are concerned the situations is reversed. Here the percentage of female patients hospitalised is higher than that of the male patients. The percentage for female patients who are under the category of married, divorced and widowed are 53.7% 56.41%, and 77.97% respectively, while that of the male patients hospitalised are 46.3% and 22.03% respectively. (Combining the three categories of marital status the percentages for male and female patients are 37.3% and 62.70% respectively). Another aspect that can be seen is the marked difference between the percentage of widowed female patients and widowed male patients hospitalised. Here the total number of widowed female patients is more than three times that of the widowed male patients, with a percentage of 77.97% and 22.03% respectively.

Let's first deal with the percentage of single male patients hospitalised. Earlier, in chapter four, the author has explained the possible reasons which may have influenced the high percentage of schizophrenic and male patients hospitalised. He

has also explained the low percentage of female patients hospitalised. From this point of view the single may be considered the ones occupying the most stressful role in the adult world.

For the low percentage of single female patients hospitalised, the reason given for the low percentage of female patients hospitalised, especially at young age, can be applied. Another factor that may have influence on the percentage is the tendency for a single female who is mentally ill to be kept as secret at home without undergoing treatment. This is because of the social stigma which may influence her future for married life. A spinster will also be socially degraded, especially in the Malay culture.

Where the high percentage of married, divorced and widowed female patients, as compared to that of the male percentage, is concerned the explaination given below may be considered as a factor that may have influenced the percentage.

It has been mentioned ealier that a woman, in early stage of her life leads a relatively uncomplicated and isolated life. She bears very little responsibility. Because of this a woman during this period, is subjected to a very limited amount of mental stress. This explains the low percentage of female patients hospitalised and the low percentage of single patients hospitalised. When a woman is married her responsibility increases. Not only there is an increase in responsibility she has also to adapt to a new mode of life style. Failing to acheive this may result to mental strain. In complicated marriage which leads to divorce the strain is made worse.

The very high percentage of widowed females hospitalised, (77.97% as compared to male percentage), shows us the pressure that is suffered by women at this stage. Since at this stage she is quite old she may not be able to attract another marriage. So she has to work in order to support her family. This may prove to be a stressful conditions compared to the ealier part of her life.

Taking the percentages of the male and female patients seperately it can be seen that on the male side the percentage of single patient hospitalised is the highest with 51.03% while on the female side the highest percentage is in the married category with 37.89% (see table XV). This strongly supports the evidence that women are generally more susceptable to stress at the married stage.

TABLE XIV: PERCENTAGE OF HOSPITALISATION ACCORDING TO MARITAL STATUS BY SEX.

MARITAL STATUS	MALE	FEMALE	TOTAL IN %
SINGLE	80.83	19.17	100
MARRIED	46.30	53.70	100
DIVORCED	43.59	56.41	100
WIDOWED	22.03	77.97	100
NOT KNOWN	59.42	40.58	100

TABLE XV: PERCENTAGE OF HOSPITALISATION ACCORDING TO SEX BY MARITAL STATUS.

MARITAL STATUS	MALE	FEMALE
SINGLE	51.03	20.47
MARRIED	19.31	37.89
DIVORCED	0.88	1.92
WIDOWED	1.34	8.01
NOT KNOWN	27.45	31.71
TOTAL IN %	100	100

1.2 MARITAL STATUS AND RACE

Ealier in chapter four we have seen how mental illness is related to race. In this chapter the author has shown in the early paragraphs the relationship that existed between mental illness and marital status. Let us now consider the two variables together, i.e. marital status and race. Table XVI shows the percentage of patients hospitalised according to marital status by race.

Among the Malays, the percentage of single patients hospitalised is 36.5%. The number of married patients hospitalised is slightly lower than that of the single patients, with a percentage of 29.82%. While the percentage for divorced and windowed patients hospitalised is 3.6% and 4.88% respectively. Among the Chinese the percentage for single patients hospitalised is 43.34% and that of the married patients is 23.72%. Here the difference between the single and married patients, in percentage, is 29.62%. The percentage for both the single and married patients of Indian origin, with 30.59% and 31.53 respectively, shows no significant difference here.

TABLE XVI: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO MARITAL STATUS BY RACE.

MARITAL STATUS	MALAY	CHINESE	INDIAN	OTHERS
SINGLE	36.50	43.34	30.59	25.00
MARRIED	29.82	23.72	31.53	12. 5
DIVORCED	3.60	0.49	0.47	-
WIDOWED	4.88	2.96	5.18	9.38
NOT KNOWN	25.19	29.49	32.24	53.12
TOTAL IN %	100	100	100	100

Comparing the differences between the single and married patients hospitalised of Malay and Chinese origin it can be seen that the two differences vary in degree. Where the Chinese patients are concerned the difference is very big with 29.62%, while the difference in the Malay patients is comparatively small with 6.68%.

The big difference between the single and married Chinese patients hospitalised is due to the high percentage of single patients (43.34%) and the low percentage of married patients hospitalised (23.72%), while the small difference among the Malay patients hospitalised is because of the low percentage of single patients (36.5%) and the high percentage of married patients hospitalised (29.82%).

The high percentage of single Chinese patients hospitalised may be related to the high percentage of Schizophrenion hospitalised, since Schizophrenia is mainly diagnosed among the younger patients who are single mostly. It may also be related to the high degree of mental strain that they are subjected to. In the case of the Malays, the low percentage of single patients hospitalised may be explained as follows: Firstly, it may be due to the amount of mental stress that they are subjected to which is low. This is especially true among the Malay females. Secondly, it may have its relationship with the Malay beliefs towards mental illness, as mentioned in chapter two, which affected the number patients hospitalised, in this case a low percentage.

Comparing the percentages of divorced patients hospitalised of the various races an interesting phenomenon can be seen. From table XVI the percentage of the divorced Malay patients is 3.6% while for the Chinese and Indians, percentages of 0.49% and 0.47% are recorded respectively. Looking at this in a different perpective, i.e. by

taking the percentage of divorced patients hospitalised only, the percentages for the Malays, Chinese and Indians are 71.79%, 23.08% and 5.13% respectively. See additional table XXVII in appendix II.

Thus, in this case, the divorced Malay patients show a very high percentage of hospitalisation. While the percentages for the Chinese and Indians are low.

A high percentage of divorced Malay patients hospitalised may be the result of an increase in the amount of mental stress that they are subjected to as mentioned ealier in chapter three. It may also be related to the rate of divorce in the Malay community. There seems to be a high rate of divorce among the Malays. Unfortunately the author is not able to produce any data on this.

In the case of the Chinese the low percentage of hospitalisation of divorced patients may have its relations, firstly, with the low rate of divorced in their community. Secondly, it may be related to the low amount of stress comparatively. Divorce may not lead to much pressure here.

The Indian low percentage of divorced patients hospitalised may be explained in the same manner as in the case of the Chinese.

In summary, the author finds that the basic hypothesis suggested earlier in this study, where frequency of mental illness suffered by persons who are unmarried is far greater than those who are married, divorced or widowed, can be held tentatively as being of some validity. The validity of this hypothesis is evidenced in the high percentage of single patients hospitalised. However, when sex is controlled it is found that among the female patients the percentage of married patients is highest.

Where relationship between types of illness and marital status is concerned the author is not able to make any conclusion though the data shows some significant relationship between the two variables. This is due to the nature of records maintained by the hospital as mentioned ealier.

2 MENTAL ILLNESS AND SIBLING RANK

Though no study has yet been made on the relationship between mental illness and sibling rank in Malaysia a number of studies have been done in countries like Taiwan, Japan and America. In Taiwan, a study has been done by Dr. Hsien Rin on this subject. The findings of his study shows that among the psychotics the rate of prevalence is high among first-born males; and the last-born females show a high rate of prevalence among patients with psychophysiological reaction(15).

William Caudill, in his study of Japanese patients in 1963, found an over representation among same-sex living siblings of eldest sons and youngest daughters among psychotic patiets. When he only analysed the data of schizophrenic patients first-born males and last-born females again were over representated among same-sex living birth rank (16).

Several studies in North America have supported the hypothesis that last-born are more likely to be hospitalised in mental hospitals than first-born. Malzburg's (1940) data on first admissions with

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(15) The detailed findings on this study can be referred to in Caudill and Lin (Ed.), op. cit. Page 105-112.

(16) Caudill and Lin (Ed.), Ibid., Page 114-146.

dementia praecox (schizophrenia) between 1939 and 1935 at Manhanttan state hospital showed more last-born than first-born patients of families with four or more children. Gregory's (1959) family data of 1,000 patients admitted to Ontario Hospital between 1954 and 1958 also showed more last-born than first-born patients in this population. Schooler (1961) collected data on a sample of hospitalised female schizoprenics in Springfield State Hospital during 1959 and found that significantly more patients came from the last half of their sibship than from the first half (Caudill and Lin, 1966 Page III).

In this study made at Hospital Bahagia, Ulu Kinta the author has taken a sample of 515 patients hospitalised of which 316 were males and 199 females. Table XVII below shows the distribution of patients according to sibling rank by types of mental illness.

TABLE XVII: PERCENTAGE OF PATIENT HOSPITALISED ACCORDING TO SIBLING RANK

DIAGNOSTIC GROUP	FIRST-BORN	LAST-BORN
SCHIZOPHRENIA	59.34	17.21
MELANCHOLIS	-	0.37
DEPRESSION	2.19	0.37
MANIC DEPRESSIVE PSYCHOSIS	2.57	2.56
DEMENTIA	-	0.37
OTHER PSYCHOSIS	2.19	-
NEUROSIS	0.73	-
OBSERVATION	1.47	-
NO INFORMATION	6.96	3.29
TOTAL IN%	75.46	24.54

From this table it can be seen that the first-born has a very high percentage of hospitalisation as compared to the last-born, with

75.46% and 24.54% respectively.

The question that arises here is why there is a high percentage of first-born patients hospitalised? One selective factor for this may lie in the importance of the eldest child to the family. Because of this parents will seeks for more medication for them and thus this may influence the number of patients hospitalised.

The importance of the eldest is viewed in term of their responsibilities to the family and this may increase the amount of pressure they have to bear and thus may cause more breakdowns among them. In addition, because the eldest child is frequently pampered and overprotected by mothers and grandmothers, (being the first child), they may find it even more difficult to adjust when the time comes for them to assume their responsibilities as eldest child.

When sex is teken into account as shown in table XVIII below it seems that the high percentage of first-born patients hospitalised occurs for both males and females. The percentage for first-born males as compared to last-born is 76.5% and that the first-born female patients as compared to the last-born females hospitalised is 72.5%

TABLE XVIII: PERCENTAGE OF HOSPITALISATION ACCORDING TO SIBLING RANK BY SEX

SIBLING RANK	MALE	FEMALE
FIRST-BORN	76.5	72.5
LAST-BORN	23.5	27.5
TOTAL IN%	100	100

Let us now proceed further to include sex and race variables (See table XIX).

First, let us start with the Malay patients. From the table the first-born for both sexes as compared to the last-born patients shows a very high percentage of hospitalisation. The percentage for first-born male is 73% and that of the first-born females is 95.2%.

The percentage of first-born patients for both sexes among the Chinese is also high as compared to the last-born. For the first-born male hospitalised the percentage is 79.8% but where the percentage for first-born females hospitalised is concerned the difference is too small to be considered of any significant value.

Where the Indians are concerned a similar situation occurs. From the table the percentage for first-born male as compared to the last-born male is 75% and that for the first-born female hospitalised, as compared to the last-born female, is 92.9%.

One very interesting phenomenon to be observed here is the exceptionally how percentage of the last-born male patients of Malay and Indian origin as compared to that of Chinese origin. This could be due to the high importance the Chinese place on the male, be he first-born or last-born.

To summarise the findings of this study we have firstly, an over representation of the first-born patients hospitalised. Secondly, when sex is taken into consideration, it is found that for both sexes, the first-born is still overrepresentated. Lastly, with the inclusion of race variable, it is found that an overrepresentation of the first-born exist for the three races for both sexes, with the exception of the Chinese first-born male patients.

TABLE XIX: PERCENTAGE OF HOSPITALISATION BY SIBLING RANK (RACE AND SEX CONTROLLED).

SIBLING RANK	MALAY		CHINESE		INDIAN	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
FIRST-BORN	95.2	73.	58.9	79.2	92.9	75
LAST-BORN	4.8	27.	41.1	20.8	7.1	25
TOTAL IN %	100.	100.	100.	100.	100.	100

CHAPTER SIX

OCCUPATION, SOCIAL CLASS AND AREA OF RESIDENCE IN RELATION TO MENTAL ILLNESS

A review of the literature reveals that no study has yet been made on this subject here in West Malaysia. However in other parts of the world many studies have been undertaken. For example, countries like the United States of America, Africa and several countries in Asia. To mention a few of these studies, for instance we have, in the United States, August B. Hollingshead and Frederick C. Relich (1958) who made a study on the relationship between mental illness and social class; Robert E. Farris and H. Warren Dunham (1939) with their study on mental illness in urban areas; and R.M. Frumkin (1952) who studied on occupation in relation to mental illness. In Africa, we have Carother's study in Kenya and in India there is Shaw and Dhunjiboy.

1. MENTAL ILLNESS AND OCCUPATION

The question of occupation in relation to mental illness here is viewed in terms of income and prestige it displays, i.e. whether occupational income and occupational prestige in low or high. From the few studies made whereby the problem of occupation and mental illness is directly or indirectly considered the findings show, in general, that there exists an inverse relationship between the prevalence of mental illness and income prestige as manifested in

occupation; that there also exists a relationship between the types of mental illness and occupation; and that a man's occupation is more important to his mental health than is the occupation of a woman to her mental health (17).

However, occupation is quite closely related to social status of an individual. This is because occupation is usually used as one of the indicators in measuring social status. (This question will be discussed in the later section of this chapter when the author deals with the relationship between mental illness and social class). Therefore, the validity of the findings in this section depends partly on the degree of consistency of findings between the two(occupation and social status) in relation to mental illness.

Using these findings as guidelines a hypothesis is postulated which states that the prevalence and types of mental illness is significantly related to occupation.

In this study, the author classified occupations into various categories in their order of importance (18) as follows:

(i) Professional and semi-professional group

(ii) Managerial and administrative group.

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(17) For a detail analysis of the findings please see R.M. Frumkin, "Occupation and Major Mental Disorders" in Arnold M. Rose (Ed.), "Mental Health and Mental Disorder," Routledge and Kegan Paul Ltd., London 1956; C. Landis and J.D. Page, "Modern Society and Mental Disease" (New York : Farrar and Rinehart, 1938); R.E. Clark, "The Relationship of Schizophrenia to Occupational Income and Prestige," American Sociological Review, 13 (June 1948), p.p. 325-330; R.E. Clark, "Psychoses, Income and Occupational Prestige," American Journal of Sociology, 54 (1949), p.p. 433-440.

(18) The order of importance of these occupational groups however is very flexible. To draw a demarcation line between each group had proved to be very difficult. This is very true especially in the lower income group. The classification of these occupational groups here however is purely derived from the author's opinion. Other people may classify them in different order.

(iii) Clerical group
(iv) Sale and small business group
(v) Skilled group
(vi) Agricultural workers
(vii) Unskilled workers
(viii) Unemployed

Let us now proceed with the findings to see whether there exists a relationship between occupation and mental illness. From Table XX there seems to be a definite correlation between the two variables. Here the percentage of hospitalisation seems to decrease as the status of the occupation in terms of income and prestige increases, i.e. the higher the status of occupation the lower is the percentage of patients hospitalised. In other words the percentage of hospitalisation is inversely related to status of occupation.

Patients under 'Unemployed group' show the highest percentage of hospitalisation, with 49.34%. Though the unemployed do not come under any occupational group, but because occupation is considered in terms of income and prestige this group is categorised as the lowest in order of importance. The second highest group of patients hospitalised is the 'unskilled workers.' The percentage of hospitalisation for this group is 26.85%. Patients under 'Agricultural group' is third highest with a percentage of 14.69%. The percentage of hospitalisation decreases further to as low as 1.72% among patients under 'Clerical group.' Under occupational groups of "Professional/semi-professional" and "Managerial/administrative" there seems to be no patients hospitalised.

Analysing the types of mental illness in relation to occupation the author finds that only schizophrenia seems to show some con-

TABLE XX: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO TYPE OF ILLNESS BY OCCUPATION

DIAGNOSTIC GROUPS	PROFESSIONAL AND SEMI-PROFESSIONAL	MANAGERIAL	CLERICAL	SALE/ BUSINESS	SKILLED	AGRICULTURE	UNSKILLED	UNEMPLOYED
SCHIZOPHRENIA	-	-	1.09	2.63	2.36	10.93	18.49	31.84
MELANCHOLIA	-	-	-	-	-	0.09	0.28	0.41
DEPRESSION	-	-	0.05	0.05	0.05	0.05	-	1.09
MANIC-DEPRESSIVE PSYCHOSIS	-	-	0.09	0.18	0.36	0.77	-	2.31
DEMENTIA	-	-	0.05	0.18	-	0.27	0.68	1.27
OTHER PSYCHOSIS	-	-	0.09	-	0.23	0.05	0.41	0.91
NEUROSIS	-	-	0.05	0.05	0.05	-	-	0.23
OBSERVATION	-	-	-	0.05	0.14	0.27	0.19	0.54
NO INFORMATION	-	-	0.30	0.44	0.76	2.08	4.53	10.74
TOTAL	-	-	1.72	3.58	3.81	14.69	26.85	49.34

crete relationship with occupation. Looking at Table XX again it can be seen that the percentage of patients hospitalised under occupational groups of "Agriculture," "Unskilled," and "Unemployed" is very high, with 10.93%, 18.49% and 31.84% respectively. In fact this high percentage greatly influenced the high percentage of patients hospitalised under the above-mentioned occupational groups.

Where other types of illness are concerned their percentages seem to be randomly distributed in all occupational groups.

Judging from the above situation the author is left with no choice but to assume at the moment that relationship between types of mental illness and occupation is non existence.

1.1 OCCUPATION AND RACE

It has been shown earlier that there exists an inverse relationship between mental illness and occupation. One question that arises here is whether this relationship still exists if race is controlled. It can be seen from Table XXI that for the Malays and Indians the relationship is not so strong. Among the Malays, the percentage for 'Clerical' and 'Sale/business' group (1.35% and 1.35% respectively) is higher than that for the 'Skilled' group which is 1.18%. The percentage for 'Agricultural' group which should be lower than that of the 'Unskilled' group is higher instead.

Murphy, in his study on mental illness in Singapore, found that among the Malays the categories which show the least mental illness are clearly those not associated with wealth and prestige, or with agriculture, but those associated with least effort and initiative. The categories showing the highest rates, on the other hand, are those in which the most effort, either mental or physical,

is required (Opler, Page 306, 1959). But, from the finding of this study, it seems that this is not the case here.

Using the same table, it seems that among the Chinese the percentage of hospitalisation is inversely related to occupation as mentioned earlier. A low percentage of hospitalisation is found to be associated with a high status occupational group and vice versa.

In the case of the Indians the percentage of hospitalisation is quite similar to that of the Malay pattern in the sense that it does not show an inverse relationship between mental illness and occupation. However, the author finds that it is not possible to state any particular reason for this phenomenon.

TABLE XXI: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO RACE BY OCCUPATION

OCCUPATION	MALAY	CHINESE	INDIAN	OTHERS
PROFESSIONAL/ SEMI PROFESSIONAL	-	-	-	-
MANAGERIAL	-	-	-	-
CLERICAL	1.35	1.69	2.71	-
SALE/BUSINESS	1.35	5.08	1.69	-
SKILLED	1.18	5.47	1.69	7.62
AGRICULTURAL	30.81	8.27	11.54	7.62
UNSKILLED	26.43	23.91	42.37	7.62
UNEMPLOYED	38.88	55.58	40.00	77.14
TOTAL	100.00	100.00	100.00	100.00

1.2 OCCUPATION AND SEX.

We have seen earlier how mental illness is related to occupation. Let us now see whether there is a relationship between the two variables when sex variable is taken into consideration. From

Table XXII below it can be seen that in all occupations the percentage of male patients hospitalised exceeds that of the female greatly. For example, in the 'skilled' group and the 'sale/business' group the percentage for female patients hospitalised is 9.52% and 2.53% respectively, compared to that of the male patients which is 90.48% and 97.47% respectively.

TABLE XXII: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO OCCUPATION BY SEX

OCCUPATION	MALE	FEMALE
PROFESSIONAL/ SEMI-PROFESSIONAL	-	-
MANAGERIAL	-	-
CLERICAL	84.21	15.79
SALE/BUSINESS	97.47	2.53
SKILLED	90.48	9.52
AGRICULTURAL	81.17	18.83
UNSKILLED	86.15	13.85
UNEMPLOYED	46.10	53.90

Thus it can be deduced that occupation is more closely related to the percentage of males hospitalised than it is to the percentage of the female patients hospitalised. In other words a man's occupation, in general, is probably more important to his mental health than is that of a woman. This is because to the men, a job is their means to ego satisfaction, i.e. the means by which they maintain their personal integrity. In the case of women the goal of ego satisfaction is achieved through their status as wives, mothers, or through the status of their husbands, rather than through a job other than that of housewife. The high percentage of female patients hospitalised

under 'unemployed group,' with 53.9% established the fact that less women are involved in working life.

2. MENTAL ILLNESS AND SOCIAL CLASS

A study on mental illness in relation to social class has been done by Redlich and Hollingshead in New Haven Community (U.S.A.) in 1959. In this study the community is categorised into five different social classes. The classification is made by the use of Index of Social Position which is based on three scaled factors within the community's stratification systems - ecological area of residence, occupation and education (19). Some major findings of this study showed firstly, that the prevalence of mental illness is related inversely to social class, i.e. the lower the class the higher is the rate of prevalence. Secondly, that types of mental illness is significantly connected to social class. In the upper class neurotic patients predominates while in the lower class majority of the patients are diagnosed under psychosis. Thirdly, that the types of psychiatric treatment a patient receives is related to his position in the class structure. Here they discovered that psychotherapy is concentrated in the upper classes, while in the lower class the percentage of patients receiving no treatment care (custodial) and organic treatment is greatest.

In this study the patients are categorised into three classes (20). Classification is based on two factors - occupation and income. Where government servants are concerned the classification

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(19) An explanation on how the Index of Social Position is being utilised can be found in their book 'Social Class and Mental Illness,' Appendix 2, Page 387 - 397.

(20) This classification is made by Hospital Bahagia, Ulu Kinta. Datas on social class of patients produced in this section is formulated by the author basing solely on this classification.

of patients is based practically on the income factor alone as follows:

CLASS I (Upper Class)	-	Officers receiving a salary of not less than $525.00 per month
CLASS II (Middle Class)	-	Officers receiving a salary of between $180.00 to $524.00 per month.
CLASS III (Lower Class)	-	Officers whose salary is less than $180.00 per month.

In the case of patients from private sector classification is determined according to his occupation and income. Unfortunately the author is not able to elaborate on this since a detail information given to him seems to be rather inconsistent and misleading.

Considering the fact that the method of classification of patients into social class is rather weak the author feels it is important that the readers be informed about it. Thus whatever findings in this particular section must not be taken into consideration seriously.

However basing on the existing records, datas on the relationship between mental illness and social class are formulated. From Table XXIII it seems that there is a relationship between the two variables. It is shown that a high percentage of patients hospitalised is found to be concentrated in the lower class (Class III) with 72.49%. In the upper class (Class I) and middle class (Class II) the percentage of hospitalised patients is comparatively very low (0.81 and 1.81% respectively). In other words, the table suggests that the percentage of hospitalisation is high where social class is low and that the percentage is low where social class is high.

TABLE XXIII: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO TYPE OF ILLNESS BY SOCIAL CLASS.

DIAGNOSTIC GROUPS	CLASS I	CLASS II	CLASS III	UNKNOWN
SCHIZOPHRENIA	0.58	1.1	46.05	14.76
MELANCHOLIA	-	-	0.42	0.32
DEPRESSION	-	0.07	0.78	1.07
MANIC-DEPRESSIVE PSYCHOSIS	0.03	-	4.85	1.46
DEMENTIA	0.03	0.03	1.81	0.44
OTHER PSYCHOSIS	-	0.03	1.68	1.42
NEUROSIS	0.03	0.19	0.1	0.03
OBSERVATION	-	0.03	1.39	0.19
NO INFORMATION	0.13	0.36	15.41	5.15
TOTAL	0.81	1.81	72.49	24.89

As shown in Table XXIV below where race is controlled, it seems that the high percentage of hospitalised patients in the low class group is similar among the three races - Malay, Chinese and Indian. However variation on the percentage of hospitalisation is apparent.

TABLE XXIV: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO RACE BY SOCIAL CLASS

RACE	CLASS I	CLASS II	CLASS III	UNKNOWN
MALAY	0.51	1.03	80.59	17.87
CHINESE	0.86	2.	72.99	24.15
INDIAN	0.94	1.88	55.06	42.12
OTHERS	3.12	9.38	78.12	9.38

Thus it can be summed up that the hypothesis suggested earlier in this study, that the frequency and types of mental illness is related significantly to the individual's position in the class structure of his society, can be accepted to be as partly valid. It is partly valid because the second part of the hypothesis which concerned the

types of illness in relation to social class could not be proved. The validity of the hypothesis is evidenced in the high percentage of patients hospitalised from the low class group. However the validity of this hypothesis depends also on the method used for the classification of social class. Knowing that the method used is weak, it is therefore questionable whether the validity can be accepted as tenable.

3. MENTAL ILLNESS AND TYPE OF RESIDENCE

Many studies have been made on the relation between mental illness and ecological area of residence. These studies showed, among other things, that the prevalence of mental illness in rural (and primitive) societies is lower than the rate found in societies which are urbanised. It has also been found that the types of illness is significantly related to area of residence.

E. Farris claimed that schizophrenia, the commonest of the psychoses, was rare among the Forest Bantus of Africa who had little contact with western civilization. A similar view was expressed by Lopez, Devereaux and others. Carother's observations in Kenya showed that the prevalence of mental illness among native Africans was much lower than among Europeans and also that, among African themselves a considerable difference was noticed; those living on reservation being less exposed to mental illness than those living in cities. In India, the report of Shaw and Dhunjiboy showed that schizophrenia occurred quite frequently among highly westernised people. The study by E. Farris and Dunham on mental illness in Chicago showed a high concentration of schizophrenia in the central areas of Chicago, where the economic status was low;

whereas cases of manic-depressive psychosis showed a random geographical distribution (21). Reports from African and Asian countries where rapid industrialisation is taking place showed that neurotic disorders are on the increase. In Lin's study in Taiwan, more neurotics were found in the city than in rural areas. (Caudill (Ed.) Page 62, 1966).

From the existing data of the 3090 patients studied, there are only 555 patients where type of residence can be ascertained. As a reminder all percentages here are calculated using this 555 cases only.

Residential areas, for the purpose of this study, is classified into two - Rural and Urban. This classification is based on the Mid-Year 1971 Population Census. The categorisation of patients into the different types of residential area is taken at the time prior to his admission, i.e. his place of stay before being admitted.

Referring to Table XXV it can be seen, by all types of mental illness, that the percentage of patients hospitalised is highest in urban areas with 68.83% as compared to the percentage of patients from rural areas which is only 31.17%. Thus it can be deduced here that percentage of hospitalisation seems to be concentrated in urban areas.

Using the same table (Table XXV) we can see that the percentage of schizophrenic patients hospitalised from urban areas is

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(21) For a more detailed analysis on the findings please refer to Robert E.L. Faris and H. Warren Dunham, "Mental Disorders in Urban Areas," University of Chicago Press, Chicago, 1939.

TABLE XXV: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO TYPE OF ILLNESS BY TYPE OF RESIDENCE

DIAGNOSTIC GROUPS	RURAL	URBAN
SCHIZOPHRENIA	16.22	55.50
MELANCHOLIA	0.72	0.36
DEPRESSION	0.72	0.36
MANIC-DEPRESSIVE PSYCHOSIS	4.32	2.16
DEMENTIA	0.72	0.72
OTHER PSYCHOSIS	0.54	0.18
NEUROSIS	-	0.72
OBSERVATION	1.08	1.69
NO INFORMATION	6.85	6.24
TOTAL	31.17	68.83

higher than that of the patients from rural areas. The percentage of patients hospitalised from urban and rural areas is 55.5% and 16.22% respectively. In the case of melancholia, other psychoses and manic-depressive psychosis the percentage of hospitalisation is highest in rural areas. But the differences, in percentage, between the two areas is too small to be of any significant value.

Though the percentage of neurotic patients hospitalised is small (0.72%) it is important to note here that all the patients hospitalised are from urban areas.

3.1 TYPE OF RESIDENCE AND RACE

Table XXVI seems to show that the areal pattern among the Malays, Chinese and Indians differs.

Among the Malay patients a higher percentage of patients is concentrated in the rural areas. Here the percentage is 54.14%

while that of the urban areas is 45.86%.

Distribution of the Chinese and Indian patients is rather similar. For both races there seem to be a high concentration of patients in urban areas. Among the Chinese patients coming from urban areas the percentage is 77.17% while the percentage for the Indian patients from urban areas is 81.63%.

TABLE XXVI: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO RACE BY TYPE OF RESIDENCE

RACE	RURAL	URBAN
MALAY	54.14	45.86
CHINESE	22.83	77.17
INDIAN	18.37	81.63
OTHERS	-	100.00 *

* For this group there are only three patients recorded.

To summarise it can be said that the findings in this chapter to a certain extent, seems to coincide with many of those made in other countries as mentioned earlier. Firstly, it is found that a high percentage of hospitalisation is found to be concentrated in urban areas, while in rural areas the percentage is very low. In other words, this suggests that the prevalence of mental illness is high in urban areas. Secondly, it is found that among the psychoses, the percentage of schizophrenics is high in urban areas while of manic-depressive psychosis and melancholia a high one is recorded in rural areas. Neurosis is highly concentrated in urban areas. These suggest that types of mental illness is also related to area of residence. When race is considered, it is found that different races show a different pattern of hospitalisation

according to areas of residence.

However the validity of these findings is questionable. This is because only a small percentage of the patients is used to support them. Unfortunately this is unavoidable since many existing records maintained by the hospital is incomplete and at times inconsistent.

CHAPTER SEVEN

CONCLUSION

The readers are again reminded here that the findings in this study are based only on datas collected from Hospital Bahagia, Ulu Kinta and therefore they do not reflect the rate of mental illness but rather the rate of hospitalisation.

Some of the major findings of this study are as follows: (i) that different races react differently to mental illness. Here the Chinese are found to have the highest rate of hospitalisation; (ii) that men seem to have a higher rate of mental illness than women; (iii) that the diagnosed prevalence of mental illness decreases with age; (iv) that single patients show a higher rate of mental illness; (v) that rate of mental illness is higher with patients coming from urban areas; (vi) that occupation and social class is inversely related to mental illness; and (vii) that by sibling rank the first-born patients show a higher rate as compared to the last-born patients.

As a result of these findings the hypotheses postulated earlier have to be restructed as follows:

(i) Frequency of mental illness is expected to be significantly related to race.

(ii) The prevalence and types of mental illness is significantly related to sex.

(iii) Frequency of mental illness is expected to decrease with age and the highest frequency is at the middle ages.

(iv) Types of mental illness is also expected to be significantly related to age.

(v) Unmarried persons are more prone to mental illness than the married ones.

(vi) The frequency of mental illness is significantly related to sibling rank.

(vii) It is expected that the lower the status of the occupation the higher is the rate of mental illness.

(viii) The frequency and type of mental illness is significantly related to the individual's position in the class structure of his society.

(ix) It is expected that the frequency and type of mental illness is significantly related to ecological area of residence.

In many cases the findings in this study seem to coincide with the findings of other researches made elsewhere. However, there are quite a number of results which seem to contradict other findings, especially those made in western countries. The contradiction of these findings however may be due to the differences in culture. It may also be the result of different ways of interpreting the datas analysed. For example, the study by Hollingshead and Redlich showed that mental illness increases with age, whereas in this study the author finds that mental illness decreases with age instead.

WEAKNESS OF THE STUDY

It has been mentioned repeatedly earlier that several findings in this study cannot be taken to be as conclusive. This is

because the author feels that methodologically this study is weak. Below are listed several reasons for this.

(1) The data for psychiatric patients is only derived from patients hospitalised in Hospital Bahagia, Ulu Kinta. In this respect the actual rate of incidence cannot be established for Peninsular Malaysia.

(2) The rate of hospitalisation may be influenced by other external factors, such as culture. From this point of view we find that different ethnic groups responded differently towards hospitalisation of a mental patient. Let us take for example the Malays and the Chinese, the Malays are more tolerable towards mental patients so much so that they may be treating less severe cases at home. Here hospitalisation may also be checked as a result of the social stigma where the mentally ill persons are socially degraded. Where the Chinese are concerned, they are less tolerable towards mental patients. This may influence the rate of hospitalisation. Thus, cultural tendencies may cause a decrease in rate of hospitalisation among the Malays while on the other hand it may cause an increase rate among the Chinese.

(3) Most of the existing records on which this study is based are either inconsistent or incomplete. There are some which are illegible as a result of wear and tear. Because of this the data collected will show a high percentage of uncertain (unknown) cases, for example marital status - cases where the marital status cannot be confirmed covers about 29%. Thus, to make a conclusive statement here would be improper or rather misleading

(4) In the case of social class, the findings may be regarded

as not representative. This is because of the weakness, on the part of Hospital Bahagia, on the method used to classify the social status of the patients. The method used is very superficial and to a certain degree being influenced by the nature of the wards.

RECOMMENDATION FOR FURTHER RESEARCH

From the records maintained by the hospital it seems that we still lack the definitive knowledge on the epidemiology of mental illness. The importance of social environment and culture in understanding mental illness has not been emphasised. This may be because our society have not yet reached the stage where mental illness is seen as a social problem where it should be given a serious consideration or may be we have not really understand what mental illness is all about.

However one thing is clear, that is even at Government level emphasis on the understanding of the problem of mental illness has not been given. This is true if one studies the nature and condition of Hospital Bahagia, Ulu Kinta.

Up to date, there is not a single study yet being undertaken by any body concerned to show the importance of mental problem in relation to social and cultural variables. The author hopes this study of his, (although seems to appear weak in many respect), may create an interest on the part of society and the Government to understand and give a more serious thought over this problem. Further researches should be undertaken and must include a combination of professional workers like psychiatrist, sociologist, psychologist, antropologist and statistician so that the true nature

on the rate of incidence in relation to social and cultural factors can be ascertained. Another aspect that should be emphasised, for a better and more representative results, is that records maintained at various mental institution must be kept up to date, in the sense that particulars with regards to the patients should be complete and consistent.

The author also feels that the public should be made to understand more about mental illness through education on mental health and through some mental health programme organised by various bodies concerned. This will bring about consciousness and understanding among the people about human relations.

GENERAL

This study is designed to give a new insight upon how mental illness is related to social and cultural variables. It is hoped that society is benefitted by it as Hollingshead and Redlich put it:

"In conclusion, we want to emphasise that there are difficult and important task ahead in the new fields which have been called psychiatry and dynamic sociology. The defination of psychiatry is neither fixed nor clear. The whole field is in a stage of transistion. We do not know whether more people are psychiatrically ill today than a generation ago, but we do know that more people are treated today than were considered in need of treatment a decade ago. Psychiatry is becoming a major trouble shooter in modern society; promises and hopes are great, at times too great; fulfillment of them will come only if we are guided by the spirit of science and by a strong social conscience. Our scientific know-

ledge is rapidly increasing and shifting emphasis on our ideas about mental illness. Theories which were considered true and accepted yesterday are disapproved today and forgotten tomorrow. Solution of the mental health problem is one of the great challenges of our time. Is our society ready to meet this challenge?"

				Sex	
Identity Card	Number Colour		Place of Birth		Date of Birth
Marital Status	(State whether single, married, widowed or divorced)		Race		Religion
Place of Birth	Father		If immigrant state date of first arrival into the Federation of Malaya of (a) Patient (b) Parents.		
	Mother				
Occupation			Social Class		
Residence at date of order					
Previous residence					
Classification of Patient	(State whether Form A or B, Temporary, Voluntary, Medico-Legal)		State of Patient		
Referred by	Name				
	Address				
Whether this is first attack		Number of previous attacks		Duration of present attack	
Numbers of previous admissions, if any, to a Mental Hospital					

APPENDIX I

..... MENTAL HOSPITAL
..... STATE

PSYCHIATRIC CASE RECORD

Date Admitted				Registration Number	
Name				Sex	
Identity Card	Number Colour	Place of Birth		Date of Birth	
Marital Status	(State whether single, married, widowed or divorced)	Race		Religion	
Place of Birth	Father	If immigrant state date of first arrival into the Federation of Malaya of (a) Patient (b) Parents.			
	Mother				
Occupation		Social Class			
Residence at date of order					
Previous residence					
Classification of Patient	(State whether Form A or B, Temporary, Voluntary, Medico-Legal)	State of Patient			
Referred by	Name				
	Address				
Whether this is first attack		Number of previous attacks		Duration of present attack	
Numbers of previous admissions, if any, to a Mental Hospital					

Where and when previously under care and treatment		
Supposed cause		
Any anti-social behaviour? (Give details)		
Epileptic		
Suicidal-in what way		
Whether any relative has been afflicted with mental or nervous illness		
Name and address of nearest relative		
Diagnosis	Provisional	
	Final	
Results		(State whether Hospital Improvement, Social Improvement or Final Remission, if discharged)

MEDICAL CERTIFICATE

Facts observed by	
Facts communicated by	

COMPLAINTS

In the words of the patient	
In the words of the informant	
Degree of relationship to patient of the informant	

CASE HISTORY	
Family history	
Personal history (including previous mental health)	
Personality before illness	
History of present illness	
MENTAL STATE	
General behaviour	
Talk	

MENTAL STATE - (cont.)

Sample of talk	
Mood	
Delusions and misinterpretations	
Hallucinations and other disorders of perception	
Compulsive phenomena	
Orientation	

MENTAL STATE - (cont.)

Memory	
Attention and concentration	
General knowledge	
Intelligence	
Insight and judgement	

PHYSICAL EXAMINATION

Appearance	
General description	

PHYSICAL EXAMINATION - (cont.)

Skin		Respiratory system	
Alimentary system		Geneto-Urinary system	
Circulatory system			
Nervous system			
Anatomical peculiarities (Identification Marks)			

LABORATORY INVESTIGATION AND RESULTS

Blood	Hb.	Kahn Test	B.P.		
Faeces					
Urine	Sp. Gr.	Reaction	Alb.	Sugar	Deposits
C.S.F.	Date	Result			
Other Examinations					

APPENDIX II

TABLE XXVII: PERCENTAGE OF PATIENTS HOSPITALISED ACCORDING TO RACE BY MARITAL STATUS

MARITAL STATUS	MALAY	CHINESE	INDIAN	OTHERS:	TOTAL
SINGLE	23.16	65.58	10.6	0.65	100
MARRIED	28.64	54.33	16.54	0.49	100
DIVORCED	71.79	23.08	5.13	-	100
WIDOWED	32.20	46.62	18.64	2.54	100
UNKNOWN	21.85	60.98	15.27	1.90	100

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